

## Recommendations for Blood Pressure Measurement in Humans and Experimental Animals

### Part 1: Blood Pressure Measurement in Humans

#### A Statement for Professionals From the Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research

Thomas G. Pickering, MD, DPhil; John E. Hall, PhD; Lawrence J. Appel, MD; Bonita E. Falkner, MD; John Graves, MD; Martha N. Hill, RN, PhD; Daniel W. Jones, MD; Theodore Kurtz, MD; Sheldon G. Sheps, MD; Edward J. Roccella, PhD, MPH

**Abstract**—Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure–related risk, and to guide management. The auscultatory technique with a trained observer and mercury sphygmomanometer continues to be the method of choice for measurement in the office, using the first and fifth phases of the Korotkoff sounds, including in pregnant women. The use of mercury is declining, and alternatives are needed. Aneroid devices are suitable, but they require frequent calibration. Hybrid devices that use electronic transducers instead of mercury have promise. The oscillometric method can be used for office measurement, but only devices independently validated according to standard protocols should be used, and individual calibration is recommended. They have the advantage of being able to take multiple measurements. Proper training of observers, positioning of the patient, and selection of cuff size are all essential. It is increasingly recognized that office measurements correlate poorly with blood pressure measured in other settings, and that they can be supplemented by self-measured readings taken with validated devices at home. There is increasing evidence that home readings predict cardiovascular events and are particularly useful for monitoring the effects of treatment. Twenty-four-hour ambulatory monitoring gives a better prediction of risk than office measurements and is useful for diagnosing white-coat hypertension. There is increasing evidence that a failure of blood pressure to fall during the night may be associated with increased risk. In obese patients and children, the use of an appropriate cuff size is of paramount importance. (*Hypertension*. 2005;45:142-161.)

**Key Words:** hypertension ■ ambulatory monitoring ■ self-measurement

<b>Table of Contents</b>	
Introduction .....	144
Epidemiology of Hypertension .....	144
Overview .....	144
Systolic, Diastolic, and Pulse Pressure .....	144
Importance of Blood Pressure Variability .....	145
Classification/Subtypes of Hypertension .....	145

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This statement was approved by the American Heart Association Science Advisory and Coordinating Committee on October 13, 2004. A single reprint is available by calling 800-242-8721 (US only) or writing the American Heart Association, Public Information, 7272 Greenville Ave, Dallas, TX 75231-4596. Ask for reprint No. 71-0308. To purchase additional reprints: up to 999 copies, call 800-611-6083 (US only) or fax 413-665-2671; 1000 or more copies, call 410-528-4121, fax 410-528-4264, or e-mail kgray@lww.com. To make photocopies for personal or educational use, call the Copyright Clearance Center, 978-750-8400.

Expert peer review of AHA scientific statements is conducted at the AHA National Center. For more on AHA statement and guideline development, visit <http://www.americanheart.org/presenter.jhtml?identifier=3023366>.

This is Part 1 of a 2-part Statement. Part 2 will appear in the February 2005 issue of *Hypertension*. Both parts were published online at <http://hyper.ahajournals.org> in December 2004.

This Statement will be copublished in *Circulation* (February 8, 2005).

© 2004 American Heart Association, Inc.

*Hypertension* is available at <http://www.hypertensionaha.org>

DOI: 10.1161/01.HYP.0000150859.47929.8e

Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure Classification .....	145
Isolated Systolic Hypertension .....	145
Isolated Systolic Hypertension of the Young .....	145
Isolated Diastolic Hypertension .....	145
White Coat Hypertension or Isolated Office Hypertension .....	145
Masked Hypertension or Isolated Ambulatory Hypertension .....	146
Pseudohypertension .....	146
Orthostatic or Postural Hypotension.....	146
Blood Pressure Measurement Methods .....	146
The Auscultatory Method—Mercury, Aneroid, and Hybrid Sphygmomanometers.....	146
The Oscillometric Technique .....	147
The Finger Cuff Method of Penaz .....	148
Ultrasound Techniques.....	148
Tonometry .....	148
Location of Measurement—Arm, Wrist, Finger .....	148
Validation of Monitors.....	149
Blood Pressure Measurement in the Clinic .....	149
Subject Preparation .....	149
Choice of Blood Pressure Measurement Devices.....	149
Cuff Size .....	149
Effects of Body Position.....	150
Effects of Arm Position.....	150
Differences Between the 2 Arms.....	150
Cuff Placement and Stethoscope .....	151
Inflation/Deflation System .....	151
Observer .....	151
Number of Measurements.....	151
Automated Methods.....	152
The White Coat Effect and the Difference Between Physician and Nurse Blood Pressure Measurements .....	152
Training of Observers .....	152
Required Competencies .....	152
Training.....	152
Evaluation of Observers .....	152
Retraining.....	153
Blood Pressure Measurement in Other Settings.....	153
Acute Care.....	153
Public Places.....	153
Self-Measurement .....	153
Types of Monitor .....	153
Clinical Applications.....	154
What Is Normal Home Blood Pressure? .....	154
Prognostic Significance .....	154
Telemonitoring.....	154
Ambulatory Blood Pressure Measurement.....	154
Types of Monitor .....	154
Clinical Applications.....	155
What Is Normal ABP?.....	155
Prognostic Significance .....	155
Blood Pressure Recording Special Situations .....	155
Elderly Patients .....	155
Pulseless Syndromes .....	156
Arrhythmias.....	156
Obese Patients .....	156
Children .....	156
Pregnant Women.....	157
Summary and Recommendations .....	157

Ten years have passed since the last version of the American Heart Association (AHA) blood pressure measurement recommendations, during which time there have been major changes in the ways by which blood pressure is measured in clinical practice and research; hence, this document is a radical revision of previous versions. Blood pressure determination continues to be one of the most important measurements in all of clinical medicine and is still one of the most inaccurately performed. Hypertension is a major risk factor for coronary heart disease, stroke, and renal failure, and affects approximately one-third of the American population. The latest version of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) recommendations has drawn attention to the condition of "prehypertension," that is, people with blood pressures at the high end of the normal range, which applies to another one-quarter of the adult population. The target blood pressure for patients using antihypertensive treatment has recently been lowered for those with diabetes or renal disease.<sup>1</sup> Thus, it is becoming increasingly important to be able to detect small differences in blood pressure.

The gold standard for clinical blood pressure measurement has always been readings taken by a trained health care provider using a mercury sphygmomanometer and the Korotkoff sound technique, but there is increasing evidence that this procedure may lead to the misclassification of large numbers of individuals as hypertensive and also to a failure to diagnose blood pressure that may be normal in the clinic setting but elevated at other times in some individuals. There are 3 main reasons for this: (1) inaccuracies in the methods, some of which are avoidable; (2) the inherent variability of blood pressure; and (3) the tendency for blood pressure to increase in the presence of a physician (the so-called white coat effect).

Numerous surveys have shown that physicians and other health care providers rarely follow established guidelines for blood pressure measurement; however, when they do, the readings correlate much more closely with more objective measures of blood pressure than the usual clinic readings. It is generally agreed that conventional clinic readings, when made correctly, are a surrogate marker for a patient's true blood pressure, which is conceived as the average level over prolonged periods of time, and which is thought to be the most important component of blood pressure in determining its adverse effects. Usual clinic readings give a very poor estimate of this, not only because of poor technique but also because they typically only consist of 1 or 2 individual measurements, and the beat-to-beat blood pressure variability is such that a small number of readings can only give a crude estimate of the average level.

There are potentially 3 measures of blood pressure that could contribute to the adverse effects of hypertension. The first is the average level, the second is the diurnal variation, and the third is the short-term variability. At the present time, the measure of blood pressure that is most clearly related to morbid events is the average level, although there is also evidence accumulating that suggests that hypertensive patients whose pressure remains high at night (nondippers) are at greater risk for cardiovascular morbidity than dippers.<sup>2</sup>

Less information is available for defining the clinical significance of blood pressure variability, although it has been suggested that it is a risk factor for cardiovascular morbidity.

The recognition of these limitations of the traditional clinic readings has led to 2 parallel developments: first, increasing use of measurements made out of the clinic, which avoids the unrepresentative nature of the clinic setting and also allows for increased numbers of readings to be taken; and second, the increased use of automated devices, which are being used both in and out of the office setting. This decreased reliance on traditional readings has been accelerated by the fact that mercury is being banned in many countries, although there is still uncertainty regarding what will replace it. The leading contenders are aneroid and oscillometric devices, both of which are being used with increasing frequency but have not been accepted as being as accurate as mercury.

## Epidemiology of Hypertension

### Overview

Blood pressure is a powerful, consistent, and independent risk factor for cardiovascular disease and renal disease. According to the National Health And Nutrition Examination Survey (NHANES), at least 65 million adult Americans, or nearly one-third of the US adult population, have hypertension, defined as a systolic blood pressure  $\geq 140$  mm Hg, diastolic blood pressure  $\geq 90$  mm Hg, and/or current use of antihypertensive medication.<sup>3</sup> Another one-quarter of US adults have blood pressure in the "prehypertension" range, a systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 89 mm Hg, ie, a level above normal yet below the hypertensive range.<sup>4</sup> The prevalence of hypertension rises progressively with age, such that more than half of all Americans aged 65 years or older have hypertension.

Data from numerous observational epidemiological studies provide persuasive evidence of the direct relationship between blood pressure and cardiovascular disease. In a recent meta-analysis that aggregated data across 61 prospective observational studies that together enrolled 958 074 adults,<sup>5</sup> there were strong, direct relationships between average blood pressure and vascular mortality. These relationships were evident in middle-aged and older-aged individuals. Importantly, there was no evidence of a blood pressure threshold, that is, cardiovascular mortality increased progressively throughout the range of blood pressure, including the prehypertensive range. It has been estimated that  $\approx 15\%$  of blood pressure-related deaths from coronary heart disease occur in individuals with blood pressure in the prehypertensive range.<sup>6</sup>

Individual trials and meta-analyses of clinical trials have conclusively documented that antihypertensive drug therapy reduces the risk of cardiovascular events in hypertensive individuals. Such evidence provides strong evidence for current efforts to identify and treat individuals with hypertension and for parallel efforts to identify individuals with prehypertension, who are at risk for hypertension and blood pressure-related morbidity.

### Systolic, Diastolic, and Pulse Pressure

Several dimensions of blood pressure are associated with an increased risk of vascular disease. Clinic-based measure-

**TABLE 1. Classification of Hypertension (JNC-7)**

BP Classification	SBP mm Hg*	DBP mm Hg*
Normal	<120	<80
Prehypertensive	120–139	80–89
Stage 1 hypertension	140–159	90–99
Stage 2 hypertension	≥160	1≥100

\*Classification determined by higher BP category.

BP indicates blood pressure; DBP, diastolic blood pressure; SBP, systolic blood pressure.

ments that predict vascular disease include systolic and diastolic blood pressure, as well as mean arterial pressure and pulse pressure. Several studies have attempted to tease apart the relative importance of these measurements.<sup>7,8</sup> Despite evolving interest in pulse pressure, the best available evidence still supports the use of systolic and diastolic blood pressures as a means to classify individuals.

### Importance of Blood Pressure Variability

It has been suggested that blood pressure variability may be an independent risk factor for cardiovascular morbidity, on the grounds that biological materials are more susceptible to damage by changes of pressure than steady-state levels. There are many different ways of expressing blood pressure variability, ranging from beat-to-beat changes<sup>9</sup> to long-term changes between office visits.<sup>10</sup> Although there have been some studies supporting a pathological role of increased variability,<sup>10,11</sup> it remains unclear to what extent such adverse effects are a manifestation of more extensive target organ damage impairing the baroreflex regulation of blood pressure (and hence increasing blood pressure variability) as opposed to a direct effect of the variability itself.

“Labile hypertension” is a term that has been used in the past to describe blood pressure that is unusually variable, but the wider use of out-of-office monitoring has shown that lability of blood pressure is the rule rather than the exception.

### Classification/Subtypes of Hypertension

#### Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure Classification

The health risks attributable to increasing blood pressure in adults are continuous, beginning at 115/75 mm Hg.<sup>12</sup> Definitions have been established based on these risks and on the demonstrated net health benefits of blood pressure reduction. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure<sup>1</sup> (JNC 7) has continued the definition of hypertension beginning at 140/90 mm Hg for adults aged 18 or older. The classification is based on the average of ≥2 seated blood pressure measurements, properly measured with well-maintained equipment, at each of ≥2 visits to the office or clinic. Hypertension has been divided into stages 1 and 2, as shown in Table 1. JNC 7 has defined normal blood pressure as <120 and <80. The intervening levels, 120 to 139 and 80 to 89 mm Hg, are now defined as prehypertension, a group that has increasing health risks and from which definite hypertension progresses.

Current recommendations from World Health Organization, International Society of Hypertension, and European Society of Hypertension/European Society of Cardiology continue to divide stage 2 hypertension, with stage 3 beginning at ≥180 and ≥110.<sup>13</sup> They also refer to <120/<80 as optimal, 120 to 129/80 to 84 as normal, and 130 to 139/85 to 89 as high normal. Classification determined by self-measurement or ambulatory assessment is provided in those sections of this statement.

### Isolated Systolic Hypertension

As adults age, systolic blood pressure tends to rise and diastolic tends to fall. When the average systolic blood pressure is ≥140 and diastolic blood pressure is <90, the patient is classified as having isolated systolic hypertension. The increased pulse pressure (systolic–diastolic) and systolic pressure predict risk and determine treatment.<sup>14</sup>

### Isolated Systolic Hypertension of the Young

In older children and young adults, often males, the combination of rapid growth in height and very elastic arteries accentuates the normal amplification of the pressure wave between the aorta and brachial artery, resulting in a high systolic pressure in the brachial artery but normal diastolic and mean pressures. The aortic systolic pressure is normal, however. This can be suspected from pulse wave analysis or intra-aortic blood pressure measurements.<sup>15</sup>

### Isolated Diastolic Hypertension

More commonly seen in some younger adults, isolated diastolic hypertension is defined as a systolic pressure <140 and a diastolic ≥90. Although diastolic pressure is generally thought to be the best predictor of risk in patients younger than 50,<sup>16</sup> some prospective studies of isolated diastolic hypertension have indicated that the prognosis may be benign.<sup>17</sup> This topic remains controversial, however.

### White-Coat Hypertension or Isolated Office Hypertension

In ≈15% to 20% of people with stage 1 hypertension, blood pressure may only be elevated persistently in the presence of a health care worker, particularly a physician. When measured elsewhere, including while at work, the blood pressure is not elevated. When this phenomenon is detected in patients not taking medications, it is referred to as white-coat hypertension (WCH). The commonly used definition is a persistently elevated average office blood pressure of >140/90 and an average awake ambulatory reading of <135/85 mm Hg.<sup>18</sup> Although it can occur at any age, it is more common in older men and women. The phenomenon responsible for WCH is commonly referred to as the white coat effect and is defined as the difference between the office and daytime ambulatory blood pressure; it is present in the majority of hypertensive patients. Its magnitude can be reduced (but not eliminated) by the use of stationary oscillometric devices that automatically determine and analyze a series of blood pressures over 15 to 20 minutes with the patient in a quiet environment in the office or clinic. Other health risk factors are often present and should be treated accordingly. Its prognosis is discussed



further in the section on Prognostic Significance in Ambulatory Blood Pressure Measurement. In some patients, WCH may progress to definite sustained hypertension, and all need to be followed-up indefinitely with office and out-of-office measurements of blood pressure. Treatment with antihypertensive drugs may lower the office blood pressure but does not change the ambulatory measurement.<sup>19</sup> This pattern of findings suggests that drug treatment of WCH is less beneficial than treatment of sustained hypertension.

### **Masked Hypertension or Isolated Ambulatory Hypertension**

Somewhat less frequent than WCH but more problematic to detect is the converse condition of normal blood pressure in the office and elevated blood pressures elsewhere, eg, at work or at home. Lifestyle can contribute to this, eg, alcohol, tobacco, caffeine consumption, and physical activity away from the clinic/office. Target organ damage is related to the more prolonged elevations in pressure away from the physician's office and the presence of such when the blood pressure is normal in the office can be a clue.<sup>20</sup> There is also some evidence that such patients are at increased risk.<sup>21</sup>

### **Pseudohypertension**

When the peripheral muscular arteries become very rigid from advanced (often calcified) arteriosclerosis, the cuff has to be at a higher pressure to compress them. Rarely, usually in elderly patients or those with longstanding diabetes or chronic renal failure, it may be very difficult to do so. The brachial or radial artery may be palpated distal to the fully inflated cuff in these instances (positive Osler sign). The patients may be overdosed with antihypertensive medications inadvertently, resulting in orthostatic hypotension and other side effects. When suspected, an intra-arterial radial artery blood pressure can be obtained for verification. The Osler maneuver is not a reliable screen for pseudohypertension. It was present in 7.2% of 3387 persons older than 59 years screened for the Systolic Hypertension in the Elderly Program (SHEP) study—more common in men, those found to be hypertensive, and those with a history of stroke.<sup>22</sup> However, the Osler maneuver may be positive in the absence of pseudohypertension in one-third of hospitalized elderly subjects.<sup>23</sup>

### **Orthostatic or Postural Hypotension**

Orthostatic hypotension is defined as a reduction of systolic blood pressure of at least 20 mm Hg or 10 mm Hg in diastolic blood pressure within 3 minutes of quiet standing.<sup>15</sup> An alternative method is to detect a similar fall during head-up tilt at 60 degrees. This may be asymptomatic or accompanied by symptoms of lightheadedness, faintness, dizziness, blurred vision, neck ache, and cognitive impairment. Factors affecting this response to posture include food ingestion, time of day, medications, ambient temperature, hydration, deconditioning, standing after vigorous exercise, and age.<sup>24,25</sup> If chronic, the fall of blood pressure may be part of pure autonomic failure, multiple system atrophy, associated with Parkinsonism or a complication of diabetes, multiple myeloma, and other dysautonomias. Patients with autonomic failure exhibit a disabling failure of control of many auto-

nomous functions. The major life-limiting failure is inability to control the level of blood pressure, especially in those patients with orthostatic hypotension who concomitantly have supine hypertension. In these patients, there are great and swift changes in pressure so that the patients faint because of profound hypotension on standing and have very severe hypertension when supine during the night. Often the heart rate is fixed as well. The supine hypertension subjects them to life-threatening target organ damage such as left ventricular hypertrophy, coronary heart disease, flash pulmonary edema, heart failure, renal failure, stroke, and sudden death (presumably caused by central apnea or cardiac arrhythmias).<sup>26–28</sup>

### **Blood Pressure Measurement Methods**

The auscultatory method has been the mainstay of clinical blood pressure measurement for as long as blood pressure has been measured but is gradually being supplanted by other techniques that are more suited to automated measurement.

### **The Auscultatory Method—Mercury, Aneroid, and Hybrid Sphygmomanometers**

It is surprising that nearly 100 years after it was first discovered, and the subsequent recognition of its limited accuracy, the Korotkoff technique for measuring blood pressure has continued to be used without any substantial improvement. The brachial artery is occluded by a cuff placed around the upper arm and inflated to above systolic pressure. As it is gradually deflated, pulsatile blood flow is re-established and accompanied by sounds that can be detected by a stethoscope held over the artery just below the cuff. Traditionally, the sounds have been classified as 5 phases: phase I, appearance of clear tapping sounds corresponding to the appearance of a palpable pulse; phase II, sounds become softer and longer; phase III, sounds become crisper and louder; phase IV, sounds become muffled and softer; and phase V, sounds disappear completely. The fifth phase is thus recorded as the last audible sound.

The sounds are thought to originate from a combination of turbulent blood flow and oscillations of the arterial wall. There is agreement that the onset of phase I corresponds to systolic pressure but tends to underestimate the systolic pressure recorded by direct intra-arterial measurement.<sup>29</sup> The disappearance of sounds (phase V) corresponds to diastolic pressure but tends to occur before diastolic pressure determined by direct intra-arterial measurement.<sup>29</sup> No clinical significance has been attached to phases II and III.

The Korotkoff sound method tends to give values for systolic pressure that are lower than the true intra-arterial pressure, and diastolic values that are higher.<sup>30,31</sup> The range of discrepancies is quite striking: One author commented that the difference between the 2 methods might be as much as 25 mm Hg in some individuals.<sup>32</sup> There has been disagreement in the past as to whether phase IV or V of the Korotkoff sounds should be used for recording diastolic pressure, but phase IV tends to be even higher than phase V when compared against the true intra-arterial diastolic pressure and is more difficult to identify than phase V. There is now general consensus that the fifth phase should be used, except

in situations in which the disappearance of sounds cannot reliably be determined because sounds are audible even after complete deflation of the cuff, for example, in pregnant women, patients with arteriovenous fistulas (eg, for hemodialysis), and aortic insufficiency.<sup>33–35</sup> Most of the large-scale clinical trials that have evaluated the benefits of treating hypertension have used the fifth phase.

In older patients with a wide pulse pressure, the Korotkoff sounds may become inaudible between systolic and diastolic pressure, and reappear as cuff deflation is continued. This phenomenon is known as the auscultatory gap. In some cases, this may occur because of fluctuations of intra-arterial pressure and is most likely to occur in subjects with target organ damage.<sup>36</sup> The auscultatory gap often can be eliminated by elevating the arm overhead for 30 seconds before inflating the cuff and then bringing the arm to the usual position to continue in the measurement. This maneuver reduces vascular volume in the limb and improves inflow to enhance the Korotkoff sounds. The auscultatory gap is not an issue with nonauscultatory methods.

### **Mercury Sphygmomanometers**

The mercury sphygmomanometer has always been regarded as the gold standard for clinical measurement of blood pressure, but this situation is likely to change in the near future, as discussed. The design of mercury sphygmomanometers has changed little over the past 50 years, except that modern versions are less likely to spill mercury if dropped. In principle, there is less to go wrong with mercury sphygmomanometers than with other devices, and one of the unique features is that the simplicity of the design means that there is negligible difference in the accuracy of different brands, which certainly does not apply to any other type of manometer. However, this should not be any cause for complacency. One hospital survey found that 21% of devices had technical problems that would limit their accuracy,<sup>37</sup> whereas another found >50% to be defective.<sup>38</sup> The random zero sphygmomanometer was designed to eliminate observer bias but is no longer available.

### **Aneroid Sphygmomanometers**

In these devices, the pressure is registered by a mechanical system of metal bellows that expands as the cuff pressure increases and a series of levers that register the pressure on a circular scale. This type of system does not necessarily maintain its stability over time, particularly if handled roughly. They therefore are inherently less accurate than mercury sphygmomanometers and require calibrating at regular intervals. Recent developments in the design of aneroid devices may make them less susceptible to mechanical damage when dropped. Wall-mounted devices may be less susceptible to trauma and, hence, more accurate than mobile devices.<sup>39</sup>

The accuracy of the manometers varies greatly from one manufacturer to another. Thus, 4 surveys conducted in hospitals in the past 10 years have examined the accuracy of the aneroid devices and have shown significant inaccuracies ranging from 1%<sup>39,40</sup> to 44%.<sup>37</sup> The few studies that have been conducted with aneroid devices have focused on the accuracy of the pressure registering system as opposed to the

degree of observer error, which is likely to be higher with the small dials used in many of the devices.

### **Hybrid Sphygmomanometers**

Devices have been developed that combine some of the features of both electronic and auscultatory devices, and are referred to as “hybrid” sphygmomanometers. The key feature is that the mercury column is replaced by an electronic pressure gauge, such as are used in oscillometric devices. Blood pressure is taken in the same way as with a mercury or aneroid device, by an observer using a stethoscope and listening for the Korotkoff sounds. The cuff pressure can be displayed as a simulated mercury column, as a digital readout, or as a simulated aneroid display. In one version, the cuff is deflated in the normal way, and when systolic and diastolic pressure are heard a button next to the deflation knob is pressed, which freezes the digital display to show systolic and diastolic pressures. This has the potential of minimizing terminal digit preference, which is a major source of error with mercury and aneroid devices. The hybrid sphygmomanometer has the potential to become a replacement for mercury, because it combines some of the best features of both mercury and electronic devices at any rate until the latter become accurate enough to be used without individual validation.<sup>41</sup>

### **The Oscillometric Technique**

This was first demonstrated by Marey in 1876,<sup>42</sup> and it was subsequently shown that when the oscillations of pressure in a sphygmomanometer cuff are recorded during gradual deflation, the point of maximal oscillation corresponds to the mean intra-arterial pressure.<sup>43,44</sup> The oscillations begin well above systolic pressure and continue below diastolic, so that systolic and diastolic pressures can only be estimated indirectly according to some empirically derived algorithm. One advantage of the method is that no transducer need be placed over the brachial artery, so that placement of the cuff is not critical. Other potential advantages of the oscillometric method for ambulatory monitoring are that it is less susceptible to external noise (but not to low-frequency mechanical vibration), and that the cuff can be removed and replaced by the patient, for example, to take a shower. The main problem with the technique is that the amplitude of the oscillations depends on several factors other than blood pressure, most importantly the stiffness of the arteries. Thus, in older people with stiff arteries and wide pulse pressures the mean arterial pressure may be significantly underestimated.<sup>45</sup> The algorithms used for detecting systolic and diastolic pressures are different from one device to another and are not divulged by the manufacturers. The differences between devices has been dramatically shown by studies using simulated pressure waves, in which a systolic pressure of 120 mm Hg was registered as low as 110 and as high as 125 mm Hg<sup>46</sup> by different devices. Another disadvantage is that such recorders do not work well during physical activity, when there may be considerable movement artifact. Additionally, the bladders deflate at a manufacturer-specific “bleed rate,” which assumes a regular pulse between bleed steps as part of the algorithms used to determine systolic and diastolic pressure.

The oscillometric technique has been used successfully in ambulatory blood pressure monitors and home monitors. Comparisons of several different commercial models with intra-arterial and Korotkoff sound measurements have shown generally good agreement,<sup>47–49</sup> but the results have been better with ambulatory monitors than with the cheaper devices marketed for home use. Oscillometric devices are also now available for taking multiple measurements in a clinic setting.

### The Finger Cuff Method of Penaz

This interesting method was first developed by Penaz<sup>50</sup> and works on the principle of the “unloaded arterial wall.” Arterial pulsation in a finger is detected by a photoplethysmograph under a pressure cuff. The output of the plethysmograph is used to drive a servo-loop, which rapidly changes the cuff pressure to keep the output constant, so that the artery is held in a partially opened state. The oscillations of pressure in the cuff are measured and have been found to resemble the intra-arterial pressure wave in most subjects. This method gives an accurate estimate of the changes of systolic and diastolic pressure, although both may be underestimated (or overestimated in some subjects) when compared with brachial artery pressures<sup>50</sup>; the cuff can be kept inflated for up to 2 hours. It is now commercially available as the Finometer (formerly Finapres) and Portapres recorders, and has been validated in several studies against intra-arterial pressures.<sup>51,52</sup> The Portapres enables readings to be taken over 24 hours while the subjects are ambulatory, although it is somewhat cumbersome.<sup>53</sup>

This method in its present form is not suited to clinical use because of its cost, inconvenience, and relative inaccuracy for measuring absolute levels of blood pressure. Its greatest value is for research studies assessing short-term changes of blood pressure and its variability. The finger blood pressure monitors that are available in drug stores do not use this method.

### Ultrasound Techniques

Devices incorporating this technique use an ultrasound transmitter and receiver placed over the brachial artery under a sphygmomanometer cuff. As the cuff is deflated, the movement of the arterial wall at systolic pressure causes a Doppler phase shift in the reflected ultrasound, and diastolic pressure is recorded as the point at which diminution of arterial motion occurs.<sup>54</sup> Another variation of this method detects the onset of blood flow, which has been found to be of particular value for measuring systolic pressure in infants and children.<sup>55</sup>

In patients with very faint Korotkoff sounds (for example those with muscular atrophy), placing a Doppler probe over the brachial artery may help to detect the systolic pressure, and the same technique can be used for measuring the ankle–arm index, in which the systolic pressures in the brachial artery and the posterior tibial artery are compared to obtain an index of peripheral arterial disease.

### Tonometry

The principle of this technique is that when an artery is partially compressed or splinted against a bone, the pulsations are proportional to the intra-arterial pressure. This has been

developed for measurement of the blood pressure at the wrist, because the radial artery lies just over the radius bone.<sup>56</sup> However, the transducer needs to be situated directly over the center of the artery; hence, the signal is very position-sensitive. This has been dealt with by using an array of transducers placed across the artery. Although the technique has been developed for beat-to-beat monitoring of the wrist blood pressure, it requires calibration in each patient and is not suitable for routine clinical use.

Another application is applanation tonometry, in which a single transducer is held manually over the radial artery to record the pressure waveform while systolic and diastolic pressures are measured from the brachial artery. This technique has been used to estimate central aortic pressure. The rationale for this is that the arterial pressure at the level of the aortic root is different from the brachial artery pressure, and that this difference varies according to a number of physiological and pathological variables. Thus, it might be expected that the aortic pressure might predict cardiac events more closely than the brachial artery pressure. The shape of the pressure waveform in the arterial tree is determined by a combination of the incident wave and the wave reflected from the periphery. In hypertensive subjects and subjects with stiff arteries, the systolic pressure wave in the aorta and brachial artery is augmented by a late systolic peak, which can be attributed to wave reflection and which is not seen in more peripheral arteries such as the radial artery. Using Fourier analysis, it is possible to derive the central aortic pressure waveform from the radial artery trace. However, comparisons with directly recorded aortic pressure made during cardiac catheterization have shown considerable scatter between the estimated and true values,<sup>57</sup> so the technique cannot yet be recommended for routine clinical practice.

### Location of Measurement—Arm, Wrist, Finger

The standard location for blood pressure measurement is the upper arm, with the stethoscope at the elbow crease over the brachial artery, although there are several other sites where it can be performed. Monitors that measure pressure at the wrist and fingers have become popular, but it is important to realize that the systolic and diastolic pressures vary substantially in different parts of the arterial tree. In general, the systolic pressure increases in more distal arteries, whereas the diastolic pressure decreases. Mean arterial pressure falls by only 1 to 2 mm Hg between the aorta and peripheral arteries.<sup>58</sup>

### Wrist Monitors

Wrist monitors have the advantages of being smaller than the arm devices and can be used in obese people, because the wrist diameter is little affected by obesity. A potential problem with wrist monitors is the systematic error introduced by the hydrostatic effect of differences in the position of the wrist relative to the heart.<sup>59</sup> This can be avoided if the wrist is always at heart level when the readings are taken, but there is no way of knowing retrospectively whether this was performed when a series of readings are reviewed. Devices are now available that will only record a measurement when the monitor is held at heart level. Wrist monitors have potential but need to be evaluated further.<sup>60</sup>



### **Finger Monitors**

Finger monitors have so far been found to be inaccurate and are not recommended.<sup>61</sup>

### **Validation of Monitors**

All monitors in clinical use should be tested for accuracy. This involves 2 stages. First, all oscillometric automated monitors that provide read-outs of systolic and diastolic pressure should be subjected by independent investigators to formal validation protocols. The original 2 protocols that gained the widest acceptance were developed by the Association for the Advancement of Medical Instrumentation (AAMI) in 1987 and the British Hypertension Society (BHS) in 1990, with revisions to both in 1993, and to AAMI in 2002.<sup>62</sup> These required testing of a device against 2 trained human observers in 85 subjects, which made validation studies difficult to perform. One consequence of this has been that there are still many devices on the market that have never been adequately validated. More recently, an international group of experts who are members of the European Society of Hypertension Working Group on Blood Pressure Monitoring has produced an International Protocol that could replace the 2 earlier versions<sup>63</sup> and is easier to perform. Briefly, it requires comparison of the device readings (4 in all) alternating with 5 mercury readings taken by 2 trained observers. Devices are recommended for approval if both systolic and diastolic readings taken are at least within 5 mm Hg of each other for at least 50% of readings.

It is recommended that only those devices that have passed this or similar tests should be used in practice. However, the fact that a device passed a validation test does not mean that it will provide accurate readings in all patients. There can be substantial numbers of individual subjects in whom the error is consistently  $>5$  mm Hg with a device that has achieved a passing grade.<sup>64</sup> This may be more likely to occur in elderly<sup>65</sup> or diabetic patients.<sup>66</sup> For this reason, it is recommended that each oscillometric monitor should be validated on each patient before the readings are accepted. No formal protocol has yet been developed for doing this, but if sequential readings are taken with a mercury sphygmomanometer and the device, then major inaccuracies can be detected.

Another problem is that manufacturers may change the model number after a device has been tested without indicating whether the measurement algorithm has also been changed.

With nonautomatic devices, such as mercury and aneroid monitors, it is recommended that the accuracy of the pressure registration mechanism be checked. In the case of mercury sphygmomanometers, this involves checking that the upper curve of the meniscus of the mercury column is at 0 mm Hg, that the column is free of dirt, and that it rises and falls freely during cuff inflation and deflation.

Aneroid devices or other nonmercury devices should be checked by connecting the manometer to a mercury column or an electronic testing device with a Y-tube. The needle should rest at the zero point before the cuff is inflated and should register a reading that is within 4 mm Hg of the mercury column when the cuff is inflated to pressures of 100

and 200 mm Hg. The needle should return to zero after deflation.

### **Blood Pressure Measurement in the Clinic or Office**

Accurate auscultatory office blood pressure measurement is the bedrock of the diagnosis and treatment of hypertension and has been the standard method used in the major epidemiologic and treatment trials of the past 50 years. However, it is becoming increasingly clear that as it is used in everyday practice, there are major shortcomings. Thus, surveys of mercury devices in clinical practices have shown that there are frequently mechanical defects,<sup>67</sup> and physicians rarely follow official guidelines for their use.<sup>67</sup> Added to these is the phenomenon of the white coat effect, whereby the recorded blood pressure may be unrepresentative of the patient's true blood pressure.

### **Subject Preparation**

A number of factors related to the subject can cause significant deviations in measured blood pressure. These include room temperature, exercise, alcohol or nicotine consumption, positioning of the arm, muscle tension, bladder distension, talking, and background noise.<sup>28</sup> The patient should be asked to remove all clothing that covers the location of cuff placement. The individual should be comfortably seated, with the legs uncrossed, and the back and arm supported, such that the middle of the cuff on the upper arm is at the level of the right atrium (the mid-point of the sternum). Measurements made while the patient is on an examining table do not fulfill these criteria and should preferably be made while the patient is seated in a chair. At the initial visit, blood pressure should be measured in both arms. The patient should be instructed to relax as much as possible and to not talk during the measurement procedure; ideally, 5 minutes should elapse before the first reading is taken.

### **Choice of Blood Pressure Measurement Devices**

The "gold standard" device for office blood pressure measurement has been the mercury sphygmomanometer, but these are being removed from clinical practice because of environmental concerns about mercury contamination.<sup>68</sup> Mercury sphygmomanometers are already banned in Veterans Administration hospitals. There is a role for other types of device in office use, both as a substitute for the traditional mercury readings (eg, aneroid and hybrid sphygmomanometers) and as supplements to them (eg, oscillometric automatic devices). However, because there is currently no generally accepted replacement for mercury, it is recommended that, if available, a properly maintained mercury sphygmomanometer be used for routine office measurements. Mercury sphygmomanometers are critical for evaluating the accuracy of any type of nonmercury device. Nonmercury pressurometers that use electronic pressure transducers with a digital read-out are available for calibrating the pressure detection systems of aneroid or oscillometric devices.

### **Cuff Size**

Von Recklinghausen in 1901 recognized that Riva Rocci's device for determination of accurate systolic blood pressure



by palpation had a significant flaw, its 5-cm-width cuff.<sup>69</sup> Multiple authors have shown that the error in blood pressure measurement is larger when the cuff is too small relative to the patient's arm circumference<sup>70–76</sup> than when it is too large. Previous epidemiological data from Britain<sup>77</sup> and Ireland<sup>78</sup> had suggested that arm circumferences of >34 cm were uncommon. Data from NHANES III and NHANES 2000 have shown the opposite in the United States. In the United States during the period from 1988 to 2000, there has been a significant increase in mean arm circumference and an increase in the frequency of arm circumferences of >33 cm was found because of increasing weight in the American population.<sup>79</sup> This should not be surprising, because the prevalence of obesity in the United States has increased from 22.9% in NHANES III (1988 to 1994) to >30% in 2000.<sup>80</sup> Similar data regarding the increased frequency of larger arm circumferences were also found in a study of a referral practice of hypertensive subjects, in which a striking 61% of 430 subjects had an arm circumference of  $\geq 33$  cm.<sup>81</sup> Recognition of the increasing need for the "large adult" cuff, or even the thigh cuff, for accurate blood pressure measurement is critical, because frequently in practice only the standard adult size has been demonstrated to be available.<sup>82</sup> More importantly, it has been demonstrated that the most frequent error in measuring blood pressure in the outpatient clinic is "miscuffing," with undercuffing large arms accounting for 84% of the "miscuffings."<sup>83</sup>

The "ideal" cuff should have a bladder length that is 80% and a width that is at least 40% of arm circumference (a length-to-width ratio of 2:1). A recent study comparing intra-arterial and auscultatory blood pressure concluded that the error is minimized with a cuff width of 46% of the arm circumference.<sup>84</sup> The recommended cuff sizes are:

- For arm circumference of 22 to 26 cm, the cuff should be "small adult" size: 12×22 cm
- For arm circumference of 27 to 34 cm, the cuff should be "adult" size: 16×30 cm
- For arm circumference of 35 to 44 cm, the cuff should be "large adult" size: 16×36 cm
- For arm circumference of 45 to 52 cm, the cuff should be "adult thigh" size: 16×42 cm

The optimum ratios of width and length to arm circumference are shown for the small adult and standard adult cuffs. For the large adult and thigh cuffs, the ideal width ratio of 46% of arm circumference is not practical, because it would result in a width of 20 cm and 24 cm, respectively. These widths would give a cuff that would not be clinically usable for most patients, so for the larger cuffs, a less than ideal ratio of width to arm circumference must be accepted. The ideal ratio of length to arm circumference is maintained in all 4 cuffs.

In practice, bladder width is easily appreciated by the clinician but bladder length often is not, because the bladder is enclosed in the cuff. To further complicate the issue for clinicians, there are no standards for manufacturers of different sizes of blood pressure cuff. This has led to significant differences in which arm circumferences are accurately mea-

sured by individual manufacturers' standard adult and large adult cuffs.

Individual cuffs should be labeled with the ranges of arm circumferences, to which they can be correctly applied, preferably by having lines that show whether the cuff size is appropriate when it is wrapped around the arm. In patients with morbid obesity, one will encounter very large arm circumferences with short upper arm length. This geometry often cannot be correctly cuffed, even with the thigh cuff. In this circumstance, the clinician may measure blood pressure from a cuff placed on the forearm and listening for sounds over the radial artery (although this may overestimate systolic blood pressure)<sup>85</sup> or use a validated wrist blood pressure monitor held at the level of the heart.<sup>86,87</sup>

### Effects of Body Position

Blood pressure measurement is most commonly made in either the sitting or the supine position, but the 2 positions give different measurements. It is widely accepted that diastolic pressure measured while sitting is higher than when measured supine (by  $\approx 5$  mm Hg), although there is less agreement about systolic pressure.<sup>88</sup> When the arm position is meticulously adjusted so that the cuff is at the level of the right atrium in both positions, the systolic pressure has been reported to be 8 mm Hg higher in the supine than the upright position.<sup>89</sup>

Other considerations include the position of the back and legs. If the back is not supported (as when the patient is seated on an examination table as opposed to a chair), the diastolic pressure may be increased by 6 mm Hg.<sup>90</sup> Crossing the legs may raise systolic pressure by 2 to 8 mm Hg.<sup>91</sup>

In the supine position, the right atrium is approximately halfway between the bed and the level of the sternum<sup>92</sup>; thus, if the arm is resting on the bed, it will be below heart level. For this reason, when measurements are taken in the supine position the arm should be supported with a pillow. In the sitting position, the right atrium level is the midpoint of the sternum or the fourth intercostal space.

### Effects of Arm Position

The position of the arm can have a major influence when the blood pressure is measured; if the upper arm is below the level of the right atrium (when the arm is hanging down while in the sitting position), the readings will be too high. Similarly, if the arm is above the heart level, the readings will be too low. These differences can be attributed to the effects of hydrostatic pressure<sup>59</sup> and may be 10 mm Hg or more,<sup>93</sup> or 2 mm Hg for every inch above or below the heart level.

Other physiological factors that may influence the blood pressure during the measurement process include muscle tension. If the arm is held up by the patient (as opposed to being supported by the observer), the isometric exercise will raise the pressure.

### Differences Between the 2 Arms

Several studies have compared the blood pressure measured in both arms, mostly using the auscultatory technique. Almost all have reported finding differences, but there is no clear pattern; thus, the difference does not appear to be determined

by whether the subject is right- or left-handed.<sup>94</sup> One of the largest studies was conducted in 400 subjects using simultaneous measurements with oscillometric devices, which found no systematic differences between the 2 arms, but 20% of subjects had differences of >10 mm Hg.<sup>94</sup> Although these findings are disturbing, it is not clear to what extent the differences were consistent and reproducible, as opposed to being the result of inherent blood pressure variability. Nevertheless, it is recommended that blood pressure should be checked in both arms at the first examination. This may be helpful in detecting coarctation of the aorta and upper extremity arterial obstruction. When there is a consistent interarm difference, the arm with the higher pressure should be used. In women who have had a mastectomy, blood pressure can be measured in both arms unless there is lymphedema.

### Cuff Placement and Stethoscope

Cuff placement must be preceded by selection of the appropriate cuff size for the subject's arm circumference. The observer must first palpate the brachial artery in the antecubital fossa and place the midline of the bladder of the cuff (commonly marked on the cuff by the manufacturer) so that it is over the arterial pulsation over the patient's bare upper arm. The sleeve should not be rolled up such that it has a tourniquet effect above the blood pressure cuff. The lower end of the cuff should be 2 to 3 cm above the antecubital fossa to allow room for placement of the stethoscope. However, if a cuff that leaves such space has a bladder length that does not sufficiently encircle the arm (at least 80%), a larger cuff should be used, recognizing that if the cuff touches the stethoscope, artifactual noise will be generated. The cuff is then pulled snugly around the bare upper arm. Neither the observer nor the patient should talk during the measurement. Phase 1 (systolic) and phase 5 (diastolic) Korotkoff sounds are best heard using the bell of the stethoscope over the palpated brachial artery in the antecubital fossa, although some studies have shown that there is little difference<sup>90,95</sup> when using the bell or the diaphragm. The key to good measurement is the use of a high-quality stethoscope with short tubing, because inexpensive models may lack good tonal transmission properties required for accurate auscultatory measurement.

### Inflation/Deflation System

Indirect blood pressure measurement requires that occlusion of the brachial artery is produced by gradual inflation and deflation of an appropriately sized cuff. The tubing from the device to the cuff must be of sufficient length (70 cm or more) to allow for its function in the office setting. Successful inflation and deflation requires an airtight system; ongoing inspection and maintenance of the tubing for deterioration of the rubber (cracking) and the release valve are required. The cuff should initially be inflated to at least 30 mm Hg above the point at which the radial pulse disappears. The rate of deflation has a significant effect on blood pressure determination. Deflation rates >2 mm per second can lead to a significant underestimation of systolic and overestimation of diastolic blood pressure. Automated devices with a linear

deflation rate may have improved accuracy over the more common circumstances in automated devices that have stepwise deflation. It is recommended that a deflation rate of 2 to 3 mm Hg per second (or per pulse when the heart rate is very slow) be used.<sup>96,97</sup>

### Important Points for Clinical Blood Pressure Measurement

- The patient should be seated comfortably with the back supported and the upper arm bared without constrictive clothing. The legs should not be crossed.
- The arm should be supported at heart level, and the bladder of the cuff should encircle at least 80% of the arm circumference.
- The mercury column should be deflated at 2 to 3 mm/s, and the first and last audible sounds should be taken as systolic and diastolic pressure. The column should be read to the nearest 2 mm Hg.
- Neither the patient nor the observer should talk during the measurement.

### Observer

The observer is the most critical component of accurate blood pressure measurement. For accurate blood pressure measurement, the observer must: (1) be properly trained in the techniques of blood pressure measurement; (2) use an accurate and properly maintained device; (3) recognize subject factors, such as anxiety and recent nicotine use, that would adversely affect blood pressure measurements; (4) position the subject appropriately; (5) select the correct cuff and position it correctly; and (6) perform the measurement using the auscultatory or automated oscillometric method and accurately record the values obtained.

Observer error is a major limitation of the auscultatory method.<sup>98</sup> Systematic errors lead to intra-observer and inter-observer error. Terminal digit preference is perhaps the most common manifestation of suboptimal blood pressure determination. It is generally recommended that the observer should read the blood pressure to the nearest 2 mm Hg, but an inappropriate excess in the recording of "zero" as the last digit in auscultatory blood pressure determinations has been reported by multiple investigators in clinical and research settings.<sup>99,100</sup> Digit bias or digit prejudice is particularly common when the observer recognizes a specific threshold value for blood pressure and, depending on the circumstances, records a pressure just above or below that number. A good example is the Syst-Eur Trial, which showed both increased zero preference and a significant digit bias for 148 mm Hg systolic, the threshold for successful treatment in that trial.<sup>95</sup>

### Number of Measurements

It is well recognized that the predictive power of multiple blood pressure determinations is much greater than a single office reading.<sup>101</sup> One of the potential advantages of supplementing auscultatory readings with readings taken by an automated device is the ability to obtain a larger number of readings. When a series of readings is taken, the first is typically the highest. A minimum of 2 readings should be taken at intervals of at least 1 minute, and the average of those

readings should be used to represent the patient's blood pressure. If there is  $>5$  mm Hg difference between the first and second readings, additional (1 or 2) readings should be obtained, and then the average of these multiple readings is used.

### Automated Methods

Automated oscillometric blood pressure devices are increasingly being used in office blood pressure measurement, as well as for home and ambulatory monitoring. When they are used in the office, the readings are typically lower than readings taken by a physician or nurse. The potential advantages of automated measurement in the office are the elimination of observer error, minimizing the white coat effect, and increasing the number of readings. The main disadvantages are the error inherent in the oscillometric method and the fact that epidemiologic data are mostly based on auscultated blood pressure measures.

Automated devices may also offer the opportunity to avoid expensive and repetitive training of health care professionals in auscultation, which is necessary to reduce observer errors. Their use still requires careful patient evaluation for caffeine or nicotine use, selection of the correct cuff size, and proper patient positioning if accurate blood pressures are to be obtained. Devices are now available that can take a series of sequential readings and automatically average them.

### The White Coat Effect and the Differences Between Physician and Nurse Blood Pressure Measurements

The initial epidemiological studies of hypertension and the first major hypertension treatment trial (VA Cooperative Study) were performed using physician blood pressure measurements.<sup>102–104</sup> Since that time, all the major hypertension treatment trials have used a nurse, “a trained observer,” or automated blood pressure measurements. In hypertensive patients (but not necessarily in normotensive patients), the blood pressure recorded by a physician or nurse is typically higher than the average daytime level, and this difference is commonly referred to as the white coat effect.

In addition to these effects of the medical environment on blood pressure measurement, there is a recognized difference between blood pressure levels measured by a physician versus a nurse in the same subjects. In the largest study of physician–nurse blood pressure differences, it was found that a nurse recorded significantly lower mean systolic and diastolic pressures than a physician (by 6.3/7.9 mm Hg).<sup>105</sup> This difference is not caused by any difference in technique, because when a dual-headed stethoscope is used and the physician and nurse simultaneously take the blood pressure, the physician–nurse difference is insignificant. In addition, the nurse-recorded blood pressure is usually closer to the patient's daytime average pressure than the pressure recorded by the physician. Because all of the most recent treatment trials of hypertension are based on blood pressure measurements made by nurses or other professionals, but not by physicians, the difference in office blood pressure measured by physicians and nurses suggests that physician blood

pressures should not be used exclusively in the routine management of the hypertensive subject.

### Training of Observers

As the number and type of blood pressure measurement devices and direct-to-consumer advertising increase, more people are measuring blood pressure more frequently. In medical settings, physicians, nurses, nurses' aids, students, and pharmacists all measure blood pressure and record the values in a patient's records. Outside medical settings, patients, family members, or lay persons also measure blood pressure. The training given to lay observers should be as comprehensive and similar to that recommended for health care professionals in ambulatory and community settings.<sup>106</sup> With careful training even unpaid volunteers in large population surveys can measure blood pressure accurately.<sup>107</sup> However, even with the newer automated devices, the accuracy of the readings can be optimal only if all observers are appropriately trained and retrained and conscientious about using appropriate techniques.

### Required Competencies

Before training begins, potential observers should be assessed for physical and cognitive competencies required to perform the procedure. The physical requirements include the following:

- Vision. The observer must be able to see the dial of the manometer or the meniscus of the mercury column at eye level without straining or stretching, and must be able to read well enough to see the sphygmomanometer or digital display no further than 3 feet away.
- Hearing. The observer must be able to hear the appearance and disappearance of Korotkoff sounds.
- Eye/hand/ear coordination. This is required for the use of mercury and aneroid sphygmomanometers but not for the newer electronic technologies.

### Training

Traditionally, health professionals are trained in blood pressure measurement in introductory courses on physical assessment. They may receive a classroom lecture with a video on how to measure blood pressure, some laboratory skills training with demonstration and practice on fellow trainees, and mentored experience measuring blood pressure of patients, potential research subjects, or community volunteers. In clinical trials, standardized programs with audiovisual tapes that test and retest accuracy in measurement are extremely effective in training and retraining. In contrast, such training and retraining is not routinely required in nonresearch settings.

Some information is available on the Internet,<sup>108</sup> and the British Hypertension Society has a web-based video that can be used for the training and evaluation of observers.<sup>109</sup>

### Evaluation of Observers

Pencil-and-paper questionnaires or interviews can be used to assess knowledge of the correct methodology of blood pressure measurement. The evaluation of observers should



include an assessment of their knowledge of the different types of observer bias, general technique, and the interpretation of the measurements, including an understanding of the normal variability of blood pressure by time of day, exercise, timing of antihypertensive medications, etc. The observers should also know how and when to communicate blood pressure readings gathered at home or other settings to the health care professional responsible for the care of the patient and management of hypertension.

Observers should be aware of the need to use only well-maintained and calibrated equipment, choosing a quiet location with adequate room temperature, correctly positioning the person having blood pressure measured, and ensuring that the person does not talk or move during the measurement.

The skills of the observer should be demonstrated by assessing items such as positioning the patient, selecting the right size cuff, obtaining a valid and reliable measurement, recording the measurement accurately, and appropriate reporting of abnormal levels.

### Retraining

Correct blood pressure measurement technique is difficult to maintain without careful attention to all steps in the protocol and retraining. The gold standard for retraining has been set by federally funded multisite clinical trials of hypertension care and control, in which retraining is required of all blood pressure observers every 6 months. Retraining requires competency in cuff selection, patient positioning, no talking, and accurate observation of the blood pressure level by either auditory or visual assessment. Four methods of assessment are used: audio–video test tapes; Y-tube–connected simultaneous readings by 2 trained observers; a written quiz; and direct observation. In the National Heart, Lung, and Blood Institute (NLHBI)-sponsored multisite clinical trials, a senior experienced person is assigned as the central trial master trainer and a master trainer is designated for each site. The central master trainer trains the site master trainers, and they in turn train the observers at each site. This model could be replicated within hospitals, ambulatory care settings, and community agencies. Retraining of all health care professionals is strongly recommended.

## Blood Pressure Measurement in Other Settings

### Acute Care

Blood pressure measurements in acute care settings, such as the emergency department, dialysis unit, or operating suite, are usually performed to judge vital signs and volume status of the patient rather than the presence or absence of hypertension. Oscillometric devices are widely used for this purpose and may give accurate assessment of mean arterial pressure, but are often inaccurate for registering systolic and diastolic pressure.<sup>110,111</sup> Blood pressure values obtained in acute care settings are unlikely to be useful for decisions on chronic hypertension management,<sup>112</sup> because of inadequate patient preparation, faulty equipment,<sup>82</sup> and the impact of the acute illness on blood pressure. Still, high readings recorded

in the emergency room do predict hypertension on subsequent clinic visits, to some extent,<sup>113</sup> and warrant follow-up.

Blood pressure measurement is also important in the prehospital setting. Multiple techniques of blood pressure determination in the field and ambulance and helicopter transportation environments, including auscultatory, oscillometric, palpation, and use of obliteration of the pulse wave on the pulse oximeter, have been used. All of these suffer from a high degree of error that is worse with systolic blood pressures of <90 mm Hg.<sup>114–116</sup> In addition, it has been shown that standard equipment used by emergency medical services for blood pressure determination is often highly unreliable.<sup>117</sup> Determining blood pressures in prehospital settings requires a high degree of clinical experience and repetitive measurement. In this setting, establishment of trends in blood pressure before arriving in the more controlled hospital environment is more important than the absolute value of the blood pressure.

An elevated blood pressure in the acute care setting should raise the suspicion that the patient has hypertension, and a referral to the outpatient setting for further evaluation is warranted. Because of the lack of precision of blood pressure measurement (and the impact of bed rest, acute illness, medication administration, and alteration in the patient's usual diet while in the hospital), blood pressures obtained in the acute care setting should not be used to judge the adequacy of blood pressure control.

### Public Places

Automated blood pressure devices are commonly found in public places and represent a potential mechanism for increased screening for hypertension. In 1995, Whitcomb et al<sup>118</sup> reported that because the introduction of the VitaStat device in 1976, >8000 devices were in use in the United States, providing >10 million measurements per year. The initial version was the 8000 model, which was never tested by approved protocols and which was found to give very inconsistent results, particularly for systolic pressure.<sup>119–121</sup> A later model (the 90550) has been tested in a community setting and has also failed to meet the BHS or AAMI criteria for accuracy.<sup>122</sup> Other potential problems with these devices are that the cuff size (23×33 cm) is inadequate for patients with large arms, and that they are not labeled to show when or if there has been recent maintenance and revalidation of the device's performance. Clear demonstration to the user of ongoing device servicing and validation would be critical to acceptance of the devices for public blood pressure screening.

## Self-Measurement

### Types of Monitor

When self-monitoring or home-monitoring was first used, the majority of studies used aneroid sphygmomanometers.<sup>123</sup> In the past few years, automatic electronic devices have become increasingly popular. The standard type of monitor for home use is now an oscillometric device that records pressure from the brachial artery.<sup>124</sup> Unfortunately, only a few have been subjected to proper validation tests such as the AAMI and BHS protocols, and of 24 devices that have been tested by these, only 5 have passed.<sup>125</sup> An up-to-date list of validated



monitors is available.<sup>126</sup> The advantages of electronic monitors have begun to be appreciated by epidemiologists,<sup>127</sup> who have always been greatly concerned about the accuracy of clinical blood pressure measurement and have paid much attention to the problems of observer error, digit preference, and the other causes of inaccuracy described. It has been argued that the ease of use of the electronic devices and the relative insensitivity to who is actually taking the reading can outweigh any inherent inaccuracy compared with the traditional sphygmomanometer method.<sup>127</sup> This issue remains controversial, however.

Electronic devices are now available that will take blood pressure from the upper arm, wrist, or finger. Although the use of the more distal sites may be more convenient, measurement of blood pressure from the arm (brachial artery) has always been the standard method and is likely to remain so for the foreseeable future. The fact that a device has passed the validation criteria does not guarantee accuracy in the individual patient, and it is essential that each device be checked on each patient before the readings are accepted as being valid (see the previous section on Validation of Monitors). Home-monitoring devices should be checked for accuracy every 1 to 2 years.

### Clinical Applications

Home- or self-monitoring has numerous advantages over ambulatory monitoring, principal among which are that it is relatively cheap and provides a convenient way for monitoring blood pressure over long periods of time. There is some evidence that it improves both therapeutic compliance and blood pressure control.<sup>128–130</sup> However, technical, economic, and behavioral barriers have until now inhibited the widespread use of home-monitoring in clinical practice. Two technological developments, low-cost monitors with memory and systems for sending stored readings over the telephone, have the potential of overcoming these barriers.

Unfortunately, accurate readings do not guarantee accurate reporting to the physician. In 2 separate studies, patients were given home monitors, but they were not told that the devices had memory. Patients were urged to carefully record all readings, but in both studies, more than half the subjects omitted or fabricated readings.<sup>131,132</sup> Devices that have memory or printouts of the readings are therefore recommended.

It is recommended that when readings are taken, the patient should not have recently indulged in any activity such as exercise or eating that is likely to affect the blood pressure, and the patient should be resting quietly in a comfortable chair for 3 to 5 minutes with the upper arm at heart level. Three readings should be taken in succession, separated by at least 1 minute. The first is typically the highest, and the average should be used as the blood pressure reading. It is helpful to get readings in the early morning and the evening.

### What Is Normal Home Blood Pressure?

Home blood pressures are consistently lower than clinic pressures in most hypertensive patients.<sup>133</sup> Several recent studies have addressed the question of the level of home pressure that best corresponds to a normal clinic pressure of 140/90 mm Hg. The largest, the Ohasama study, proposed a

**TABLE 2. Features of Different Methods of BP Measurement**

	Clinic	Home	Ambulatory
Predicts outcome	Yes	Yes	Yes
Initial diagnosis	Yes	Yes	Yes
Upper limit of normal	140/90	135/85	135/85 (day)
Evaluation of Treatment	Yes	Yes	Limited
Assess diurnal rhythm	No	No	Yes
Cost	Inexpensive	Inexpensive	Moderate

level of 137/84 mm Hg as an acceptable upper limit for home readings<sup>134–136</sup> on the grounds that cardiovascular risk increases above this level. An ad hoc committee of the American Society of Hypertension, reviewing several studies, recommended 135/85 mm Hg as the upper limit of normal for home and ambulatory blood pressure.<sup>137</sup> As with office blood pressure, a lower home blood pressure goal is advisable for certain patients, including diabetic patients, pregnant women, and patients with renal failure.

### Prognostic Significance

One factor that has held back the wider use of self-monitoring in clinical practice has been the lack of prognostic data. Two prospective studies, 1 from Japan<sup>134–136</sup> and 1 from France,<sup>21</sup> have found that home blood pressure predicts morbid events better than conventional clinic measurements. There is an increasing body of evidence that home blood pressure may also predict target organ damage better than clinic pressure.<sup>123,138–140</sup>

### Telemonitoring

Devices are now available that have the capacity to store readings in their memory and then transmit them via the telephone to a central server computer, and then to the health care provider. They have the potential to improve patient compliance and, hence, blood pressure control.<sup>140,141</sup> Readings taken with a telemonitoring system may correlate more closely than clinic readings with ambulatory blood pressure.<sup>133</sup>

Features of different methods of BP measurement are provided in Table 2.

## Ambulatory Blood Pressure Measurement

### Types of Monitor

Ambulatory blood pressure (ABP) monitoring is a noninvasive, fully automated technique in which blood pressure is recorded over an extended period of time, typically 24 hours. It has been used for many years as a research procedure and has recently been approved by Medicare for reimbursement of a single recording in patients with suspected WCH. The standard equipment includes a cuff, a small monitor attached to a belt, and a tube connecting the monitor to the cuff. Most, but not all, ABP devices use an oscillometric technique. Of the available ABP devices, most have undergone validation testing as recommended by the AAMI or the BHS. An up-to-date list of validated monitors is available.<sup>126</sup>

During a typical ABP monitoring session, blood pressure is measured every 15 to 30 minutes over a 24-hour period

including both awake and asleep hours, preferably on a workday. The total number of readings usually varies between 50 and 100. Blood pressure data are stored in the monitor and then downloaded into device-specific computer software. The raw data can then be synthesized into a report that provides mean values by hour and period: daytime (awake), nighttime (asleep), and 24-hour blood pressure, both for systolic and diastolic blood pressure. The most common output used in decision-making are absolute levels of blood pressure, that is, mean daytime, nighttime, and 24-hour values.

The monitors can be attached by a trained technician, who should be skilled in blood pressure measurement techniques (see the previous section on Blood Pressure Measurement in Other Settings). The cuff is attached to the nondominant upper arm, and a series of calibration readings are taken with a mercury sphygmomanometer to ensure that the device is giving accurate readings (within 5 mm Hg of the mercury readings). It is important to instruct the patient to hold the arm still by the side while the device is taking a reading. It may be helpful to ask the patient to keep a diary of activities, particularly when going to bed and getting up in the morning.

### Clinical Applications

Although ABP could be used to monitor therapy, the most common application is diagnostic, that is, to ascertain an individual's usual level of blood pressure outside the clinic setting and thereby identify individuals with WCH. Other potential applications of ABP include the identification of individuals with a nondipping blood pressure pattern (eg, in diabetes), patients with apparently refractory hypertension but relatively little target organ damage, suspected autonomic neuropathy, and patients in whom there is a large discrepancy between clinic and home measurements of blood pressure. The Centers for Medicare and Medicaid Services has approved the use of ABP measurement for the diagnosis of patients with suspected WCH (documented high clinic pressures and normal pressures in other settings, and no evidence of target organ damage).

A recent overview sponsored by Agency for Healthcare Research and Quality summarized available evidence on cross-sectional associations of ABP with subclinical outcomes and on prospective associations of ABP with clinical outcomes.<sup>142</sup> In cross-sectional studies of blood pressure with left ventricular mass (22 studies) and albuminuria (6 studies), ABP levels were directly associated with both measurements. Left ventricular mass was less in individuals with WCH than in those with sustained hypertension but was greater in WCH than in nonhypertensive subjects. Such evidence suggests that WCH is an intermediate phenotype. In each of 10 prospective studies, at least one dimension of ABP predicted clinical outcomes. In studies that compared the prognostic importance of ABP to clinic measurements, ABP was usually superior to clinic measurements. In some instances, including a recent study unavailable at the time of the overview,<sup>143</sup> mean ABP levels provided additional predictive information beyond that of clinic measurements, confirming the seminal study by Perloff et al.<sup>144</sup> In a few prospective studies, WCH predicted a reduced risk of cardiovascular disease events compared with sustained hypertension.

**TABLE 3. Suggested Values for the Upper Limit of Normal Ambulatory Pressure**

	Optimal	Normal	Abnormal
Daytime	<130/80	<135/85	>140/90
Nighttime	<115/65	<120/70	>125/75
24-Hour	<125/75	<130/80	>135/85

However, data were inadequate to compare the risk associated with WCH to the risk associated with normotension. A nondipping or inverse dipping pattern predicted an increased risk of clinical outcomes. Just 2 ABP trials tested the usefulness of ABP to guide blood pressure management. Overall, available studies indicate that ABP monitoring can provide useful prognostic information.<sup>145</sup>

### What Is Normal ABP?

The normal range for ABP has been established in 2 ways: first, by comparison of the ABP level that corresponds to a clinic pressure of 140/90 mm Hg and, second, by relating ABP to risk in prospective studies. The suggested values for daytime, nighttime, and 24-hour average levels are shown in Table 3.

### Prognostic Significance

Several prospective studies have documented that the average level of ABP predicts risk of morbid events better than clinic blood pressure.<sup>136,143,144,146–149</sup> In addition to mean absolute levels of ABP, certain ABP patterns may predict blood pressure-related complications. The patterns of greatest interest are WCH and nondipping blood pressure. WCH is a pattern in which clinic blood pressure is in the hypertensive range but ABP is normal or low. Individuals with WCH are at lower risk for blood pressure-related complications in comparison to individuals with sustained hypertension. An important but unresolved issue is whether the risk of cardiovascular disease in WCH exceeds that of nonhypertensive subjects. Using both daytime and nocturnal ABP, one can identify individuals, termed nondippers, who do not experience the decline in blood pressure that occurs during sleep hours. Usually, nighttime (asleep) blood pressure drops by 10% or more from daytime (awake) blood pressure. Individuals with a nondipping pattern (<10% blood pressure reduction from night to day) appear to be at increased risk for blood pressure-related complications compared with those with a normal dipping pattern.<sup>146,150</sup> Other evidence suggests that the nighttime blood pressure may be the best predictor of risk.<sup>151</sup>

## Blood Pressure Recording in Special Situations

### Elderly Patients

Elderly patients are more likely to have WCH, isolated systolic hypertension, and pseudohypertension (see the previous section on Pseudohypertension). Blood pressure should be measured while seated, 2 or more times at each visit, and the readings should be averaged. Blood pressure should also be taken in the standing position routinely because the elderly may have postural hypotension. Hypotension is more com-

mon in diabetic patients. It is frequently noticed by patients on arising in the morning, after meals, and when standing up quickly. Self-measurements can be quite helpful when considering changes in dosage of antihypertensive medications. Ambulatory blood pressure monitoring, sometimes coupled with Holter recordings of ECGs, can help elucidate some symptoms such as episodic faintness and nocturnal dyspnea.

### **Pulseless Syndromes**

Rarely, patients present with occlusive arterial disease in the major arteries to all 4 limbs (eg, Takayasu arteritis, giant cell arteritis, or atherosclerosis) so that a reliable blood pressure cannot be obtained from any limb. In this situation, if a carotid artery is normal, it is possible to obtain retinal artery systolic pressure and use the nomogram in reverse to estimate the brachial pressure (oculoplethysmography), but this procedure and the measurement of retinal artery pressures are not generally available. If a central intra-arterial blood pressure can be obtained, a differential in pressure from a noninvasive method can be established and used as a correction factor.

### **Arrhythmias**

When the cardiac rhythm is very irregular, the cardiac output and blood pressure varies greatly from beat to beat. There is considerable interobserver and intra-observer error.<sup>152</sup> Estimating blood pressure from Korotkoff sounds is a guess at best; there are no generally accepted guidelines. The blood pressure should be measured several times and the average value used. Automated devices frequently are inaccurate for single observations in the presence of atrial fibrillation, for example, and should be validated in each subject before use.<sup>153</sup> However prolonged (2 to 24 hours) ambulatory observations do provide data similar to that in subjects with normal cardiac rhythm.<sup>154,155</sup> Sometimes, an intra-arterial blood pressure is necessary to get a baseline for comparison. If severe regular bradycardia is present (eg, 40 to 50 bpm), deflation should be slower than usual to prevent underestimation of systolic and overestimation of diastolic blood pressure.

### **Obese Patients**

A longer and wider cuff is needed for adequate compression of the brachial artery in the obese patient with a very large upper arm (see the previous section on Cuff Size). A large cuff may also be required for a big, muscular arm with a prominent biceps over which a regular, nontapered cuff might not fit smoothly. In both situations, it is particularly important to place the center of the bladder over the brachial artery pulse. If the upper arm is relatively short despite the large circumference, it may be difficult to fit a standard large adult cuff over the arm. The BHS's recommendation to use a very long cuff (12×40 cm; BHS web site August 13, 2003, <http://w3.abdn.ac.uk/BHS/booklet/special.htm>) could obviate this problem. In the rare patient with an arm circumference >50 cm, when even a thigh cuff cannot be fitted over the arm, it is recommended that the health care practitioner wrap an appropriately sized cuff around the patient's forearm, support it at heart level, and feel for the appearance of the radial pulse at the wrist. Other potential methods for measuring radial artery pressure include listening

for Korotkoff sounds over the radial artery, detecting systolic pressure with a Doppler probe, or using an oscillometric device to determine systolic blood pressure; diastolic blood pressure is largely overestimated by both methods.<sup>156</sup> The accuracy of these methods has not been validated, but they provide at least a general estimate of the systolic blood pressure. The error of overestimating the pressure when measuring with a cuff that is too small for an obese arm can be considerable and can lead to misclassification of an individual as hypertensive and to unnecessary concern and therapy.

### **Children**

Blood pressure is most conveniently measured in children by auscultation with a standard mercury sphygmomanometer. As with adults, the stethoscope is placed over the brachial artery pulse, proximal and medial to the antecubital fossa, and below the bottom edge of the cuff. The right arm is generally the preferred arm for blood pressure measurement for consistency and comparison with the reference tables.

Correct blood pressure measurement in children requires the use of a cuff that is appropriate for the size of the child's upper arm.<sup>156</sup> A technique that can be used to select a blood pressure cuff size of appropriate size is to select a cuff that has a bladder width that is at least 40% of the arm circumference midway between the olecranon and the acromion. This will usually be a cuff bladder that will cover 80% to 100% of the circumference of the arm. The equipment necessary to measure blood pressure in children 3 years of age through adolescence includes pediatric cuffs of different sizes. For newborn–premature infants, a cuff size of 4×8 cm is recommended; for infants, 6×12 cm; and for older children, 9×18 cm. A standard adult cuff, a large adult cuff, and a thigh cuff for leg blood pressure measurement and for use in children with very large arms should also be available.

Blood pressure measurements in children should be conducted in a quiet and comfortable environment after 3 to 5 minutes of rest. With the exception of acute illness, the blood pressure should be measured with the child in the seated position with the antecubital fossa supported at heart level. It is preferable that the child has feet on the floor while the blood pressure is measured, rather than feet dangling from an examination table. Overinflation of the cuff should be avoided because of discomfort, particularly in younger children. It is useful to initially inflate the cuff while palpating the pulse to estimate the approximate range for the systolic pressure and then inflate the cuff to 30 mm Hg above this estimate when the blood pressure is auscultated. The blood pressure should be measured and recorded at least twice on each measurement occasion, and the average of these 2 measurements is the measurement for systolic and diastolic blood pressure.

Systolic blood pressure is determined by the onset of the auscultated pulsation or first Korotkoff sound. The phase of the Korotkoff sounds that defines diastolic blood pressure has been somewhat controversial. The disappearance of Korotkoff sounds or fifth Korotkoff sound (K5, the last sound heard) is the definition of diastolic pressure in adults. In children, particularly preadolescents, a difference of several millimeters of mercury is frequently present between the fourth and fifth Korotkoff



sounds.<sup>157,158</sup> In some children, the Korotkoff sounds can be heard to 0 mm Hg, which has limited physiological meaning.

Elevated blood pressure measurements in a child or adolescent must be confirmed on repeated visits before characterizing a child as having hypertension. Within individual children, blood pressure at high levels tends to fall on subsequent measurement as a result of an accommodation effect (reduction of anxiety as the circumstances become more familiar) and regression to the mean, a nonbiological phenomenon that derives, in part, from mathematical considerations. Therefore, a more precise characterization of an individual's blood pressure level is an average of multiple blood pressure measurements taken for weeks or months. A notable exception to this general guideline for asymptomatic generally well children would be situations in which the child is symptomatic or has profoundly elevated blood pressure. Children who show elevated blood pressure on repeated measurement should also have the blood pressure measured in the leg as a screen for coarctation of the aorta. To measure the blood pressure in the leg, a thigh cuff or an oversized cuff should be placed on the thigh and the blood pressure measured by auscultation over the popliteal fossa. If the systolic blood pressure measured in the thigh is >10 mm Hg lower than the systolic blood pressure measured in the arm, additional studies for coarctation should be performed.

There continues to be an increase in the use of automated devices to measure blood pressure in children. These devices are easier to use and are becoming alternative instruments for blood pressure measurement when use of mercury sphygmomanometers is not permitted for ecological reasons. The most commonly used devices use oscillometric methods (see the previous section on The Oscillometric Technique). Situations in which the use of the automated devices is acceptable include blood pressure measurement in newborn and young infants in whom auscultation is difficult, as well as in an intensive care setting, where frequent blood pressure measurement is necessary. The reliability of these instruments in an ambulatory clinical setting is less clear, however.<sup>45</sup>

The interpretation of the blood pressure measurement in children requires consideration of the child's age, sex, and height. Hypertension in children and adolescents is defined as systolic and/or diastolic blood pressure that is consistently equal to or greater than the 95th percentile of the blood pressure distribution. Tables are available that provide the systolic and diastolic blood pressure level at the 95th percentile according to age, sex, and height.<sup>159</sup> These tables should be consulted to determine if the blood pressure measurements are normal or elevated. Children also demonstrate white coat effects, but the role of ambulatory blood pressure monitoring is less clear in children. Validated devices should be used, preferably in a

center with experience using ABPM. Large population-based normative data in children using ABPM are limited.<sup>160,161</sup>

### Pregnant Women

Hypertension is the most common medical disorder of pregnancy and occurs in 10% to 12% of all pregnancies. The detection of elevated blood pressure during pregnancy is one of the major aspects of optimal antenatal care; thus, accurate measurement of blood pressure is essential.<sup>161</sup> Mercury sphygmomanometry continues to be the recommended method for blood pressure measurement during pregnancy. Blood pressure should be obtained in the seated position. Measurement of blood pressure in the left lateral recumbency, on the left arm, does not differ substantially from blood pressure that is recorded in the sitting position. Therefore, the left lateral recumbency position is a reasonable alternative, particularly during labor. If the patient's upper arm circumference is 33 cm or greater, a large blood pressure cuff should be used. In the past, there had been some question as to whether the fourth (K4) or fifth (K5) Korotkoff sound should be used to define the diastolic blood pressure. The International Society for the Study of Hypertension in Pregnancy currently recommends using K5 for the measurement of diastolic blood pressure in pregnancy.<sup>161</sup> When sounds are audible with the cuff deflated, K4 should be used.

It is recognized that alternatives to mercury devices may be necessary in the future, and a small number of automated blood pressure recorders have been validated for use in pregnancy.<sup>162</sup> Self-monitoring may be useful in evaluating blood pressure changes during pregnancy.<sup>163,164</sup>

### Summary and Recommendations

Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure-related risk, and to guide management. The objective of this report is to provide clinicians with a standardized set of recommendations that, if followed, should lead to accurate estimation of blood pressure.

We recognize that many committees and organizations have published recommendations and that, in practice, blood pressure measurement remains suboptimal. In view of the consequences of inaccurate measurement, including both the risks of overtreatment and undertreatment, it is the opinion of the committee that regulatory agencies should establish standards to ensure the use of validated devices, routine calibration of equipment, and the training and retraining of manual observers. Because the use of automated devices does not eliminate all major sources of human error, the training of observers should be required even when automated devices are used.



**Disclosure**

Writing Group Member Name	Research Grant	Speakers Bureau/Honoraria	Stock Ownership	Consultant/ Advisory Board	Other
Dr Thomas G. Pickering	None	None	None	None	Patent holder of Accusphyg blood pressure monitor
Dr John E. Hall	None	None	None	None	None
Dr Lawrence J. Appel	None	None	None	None	None
Dr Bonita E. Falkner	None	None	None	None	None
Dr John W. Graves	None	None	None	None	None
Dr Martha N. Hill	None	None	None	None	None
Dr Daniel W. Jones	None	None	None	None	None
Dr Theodore Kurtz	None	None	None	None	None
Dr Sheldon G. Sheps	None	None	None	None	None
Dr Edward J. Roccella	None	None	None	None	None

This table represents the relationships of writing group members who may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit.

**References**

- Chobanian AV, Bakris GL, Black HR, Cushman WC, Green LA, Izzo JL, Jr, Jones DW, Materson BJ, Oparil S, Wright JT, Jr, Roccella EJ, Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; National Heart, Lung, and Blood Institute; National High Blood Pressure Education Program Coordinating Committee. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: the JNC 7 complete report. *Hypertension*. 2003;42:1206–1252.
- Verdecchia P, Schillaci G, Borgioni C, Ciucci A, Gattobigio R, Porcellati C. Nocturnal pressure is the true pressure. *Blood Press Monit*. 1996;1(Suppl 2):S81–S85.
- Brown MA, Davis GK, McHugh L. The prevalence and clinical significance of nocturnal hypertension in pregnancy. *J Hypertens*. 2001;19:1437–1444.
- Neaton JD, Wentworth D. Serum cholesterol, blood pressure, cigarette smoking, and death from coronary heart disease. Overall findings and differences by age for 316,099 white men. Multiple Risk Factor Intervention Trial Research Group. *Arch Intern Med*. 1992;152:56–64.
- Lewington S, Clarke R, Qizilbash N, Peto R, Collins R; Prospective Studies Collaboration. Age-specific relevance of usual blood pressure to vascular mortality: a meta-analysis of individual data for one million adults in 61 prospective studies. *Lancet*. 2002;360:1903–1913.
- Miura K, Daviglus ML, Dyer AR, Liu K, Garside DB, Stamler J, Greenland P. Relationship of blood pressure to 25-year mortality due to coronary heart disease, cardiovascular diseases, and all causes in young adult men: the Chicago Heart Association Detection Project in Industry. *Arch Intern Med*. 2001;161:1501–1508.
- Franklin SS, Larson MG, Khan SA, Wong ND, Leip EP, Kannel WB, Levy D. Does the relation of blood pressure to coronary heart disease risk change with aging? The Framingham Heart Study. *Circulation*. 2001;103:1245–1249.
- Sesso HD, Stampfer MJ, Rosner B, Hennekens CH, Gaziano JM, Manson JE, Glynn RJ. Systolic and diastolic blood pressure, pulse pressure, and mean arterial pressure as predictors of cardiovascular disease risk in men. *Hypertension*. 2000;36:801–807.
- Parati G, Saul JP, Di Rienzo M, Mancia G. Spectral analysis of blood pressure and heart rate variability in evaluating cardiovascular regulation. A critical appraisal. *Hypertension*. 1995;25:1276–1286.
- Hata Y, Muratani H, Kimura Y, Fukiyama K, Kawano Y, Ashida T, Yokouchi M, Imai Y, Ozawa T, Fujii J, Omae T. Office blood pressure variability as a predictor of acute myocardial infarction in elderly patients receiving antihypertensive therapy. *J Hum Hypertens*. 2002;16:141–146.
- Hata Y, Kimura Y, Muratani H, Fukiyama K, Kawano Y, Ashida T, Yokouchi M, Imai Y, Ozawa T, Fujii J, Omae T. Office blood pressure variability as a predictor of brain infarction in elderly hypertensive patients. *Hypertens Res*. 2000;23:553–560.
- O'Sullivan JJ, Derrick G, Foxall RJ. Tracking of 24-hour and casual blood pressure: a 1-year follow-up study in adolescents. *J Hypertens*. 2000;18:1193–1196.
- Cifkova R, Erdine S, Fagard R, Farsang C, Heagerty AM, Kiowski W, Kjeldsen S, Luscher T, Mallion JM, Mancia G, Poulter N, Rahn KH, Rodicio JL, Ruilope LM, van Zwieten P, Waeber B, Williams B, Zanchetti A; ESH/ESC Hypertension Guidelines Committee. Practice guidelines for primary care physicians: 2003 ESH/ESC hypertension guidelines. *J Hypertens*. 2003;21:1779–1786.
- Franklin SS, Khan SA, Wong ND, Larson MG, Levy D. Is pulse pressure useful in predicting risk for coronary heart Disease? The Framingham heart study. *Circulation*. 1999;100:354–360.
- Consensus statement of the definition of orthostatic hypotension, pure autonomic failure, and multiple system atrophy. *J Neurol Sci*. 1996;144:218–219.
- Franklin SS, Larson MG, Khan SA, Wong ND, Leip EP, Kannel WB, Levy D. Does the relation of blood pressure to coronary heart disease risk change with aging? The Framingham Heart Study. *Circulation*. 2001;103:1245–1249.
- Pickering TG. Isolated diastolic hypertension. *J Clin Hypertens*. 2003;5:411–413.
- Pickering TG. White coat hypertension. In: Izzo JL, Black HR, eds. *Hypertension Primer*, third edition. Dallas: American Heart Association; 2003.
- Fagard R, Staessen JA, Thijs L, Gasowsky J, Bulpiitt CJ, Clement D, de Leeuw PW, Dobovisek J, Jaaskivi M, Leonetti G, O'Brien E, Palatini P, Parati G, Rodicio JL, Vanhanen H, Webster J. Response to antihypertensive therapy in older patients with sustained and nonsustained systolic hypertension. *Circulation*. 2000;102:1139–1144.
- Pickering TG, Davidson K, Gerin W, Schwartz JE. Masked hypertension. *Hypertension*. 2002;40:795–796.
- Bobrie G, Chatellier G, Genes N, Clerson P, Vaur L, Vaisse B, Menard J, Mallion JM. Cardiovascular prognosis of “masked hypertension” detected by blood pressure self-measurement in elderly treated hypertensive patients. *JAMA*. 2004;291:1342–1349.
- Wright JC, Looney SW. Prevalence of positive Osler's manoeuvre in 3387 persons screened for the Systolic Hypertension in the Elderly Program (SHEP). *J Hum Hypertens*. 1997;11:285–289.
- Belmin J, Visintin JM, Salvatore R, Sebban C, Moulais R. Osler's manoeuvre: absence of usefulness for the detection of pseudohypertension in an elderly population. *Am J Med*. 1995;98:42–49.
- Low PA. *Clinical Autonomic Disorders: Evaluation and Management*, second ed. Philadelphia: Lippincott-Raven; 1997.
- Jordan J, Biaggioni I. Diagnosis and treatment of supine hypertension in autonomic failure patients with orthostatic hypotension. *J Clin Hypertens (Greenwich)*. 2002;4:139–145.
- Vagaonescu TD, Saadia D, Tuhim S, Phillips RA, Kaufmann H. Hypertensive cardiovascular damage in patients with primary autonomic failure. *Lancet*. 2000;355:725–726.
- Toyry JP, Niskanen LK, Lansimies EA, Partanen KP, Uusitupa MI. Autonomic neuropathy predicts the development of stroke in patients

- with non-insulin-dependent diabetes mellitus. *Stroke*. 1996;27:1316–1318.
28. Low PA, Opfer-Gehrking TL, McPhee BR, Fealey RD, Benarroch EE, Willner CL, Suarez GA, Proper CJ, Felten JA, Huck CA, et al. Prospective evaluation of clinical characteristics of orthostatic hypotension. *Mayo Clin Proc*. 1995;70:617–622.
  29. Hunyor SN, Flynn JM, Cochineas C. Comparison of performance of various sphygmomanometers with intra-arterial blood-pressure readings. *Br Med J*. 1978;2:159–162.
  30. Roberts LN, Smiley JR, Manning GW. A comparison of direct and indirect blood-pressure determinations. *Circulation*. 1953;8:232–242.
  31. Holland WW, Humerfelt S. Measurement of blood pressure: Comparison of intra-arterial and cuff values. *Br Med J*. 1964;2:1241–1243.
  32. Breit SN, O'Rourke MF. Comparison of direct and indirect arterial pressure measurements in hospitalized patients. *Aust N Z J Med*. 1974;4:485–491.
  33. Perloff D, Grim C, Flack J, Frohlich ED, Hill M, McDonald M, Morgenstern BZ. Human blood pressure determination by sphygmomanometry. *Circulation*. 1993;88(5 Pt 1):2460–2470.
  34. Petrie JC, O'Brien ET, Littler WA, de Swiet M. British Hypertension Society Recommendations on Blood Pressure Measurement. *Br Med J (Clin Res Ed)*. 1986;293:611–615.
  35. O'Brien E, Asmar R, Beilin L, Imai Y, Mallion JM, Mancia G, Mengden T, Myers M, Padfield P, Palatini P, Parati G, Pickering T, Redon J, Staessen J, Stergiou G, Verdecchia P; European Society of Hypertension Working Group on Blood Pressure Monitoring. European Society of Hypertension recommendations for conventional, ambulatory and home blood pressure measurement. *J Hypertens*. 2003;21:821–848.
  36. Cavallini MC, Roman MJ, Blank SG, Pini R, Pickering TG, Devereux RB. Association of the auscultatory gap with vascular disease in hypertensive patients. *Ann Intern Med*. 1996;124:877–883.
  37. Mion D, Pierin AM. How accurate are sphygmomanometers? *J Hum Hypertens*. 1998;12:245–248.
  38. Markandu ND, Whitcher F, Arnold A, Carney C. The mercury sphygmomanometer should be abandoned before it is proscribed. *J Hum Hypertens*. 2000;14:31–36.
  39. Yarows SA, Qian K. Accuracy of aneroid sphygmomanometers in clinical usage: University of Michigan experience. *Blood Press Monit*. 2001;6:101–106.
  40. Canzanello VJ, Jensen PL, Schwartz GL. Are Aneroid Sphygmomanometers Accurate in Hospital and Clinic Settings? *Arch Intern Med*. 2001;161:729–731.
  41. Graves JW, Tibor M, Murtagh B, Klein L, Sheps SG. The Accoson Greenlight 300, the first non-automated mercury-free blood pressure measurement device to pass the International Protocol for blood pressure measuring devices in adults. *Blood Press Monit*. 2004;9:13–17.
  42. Marey EJ. *Pression et vitesse du sang*. Physiologie Experimentale, Paris: Pratique des hautes etudes de M Marey; 1876.
  43. Mauck GW, Smith CR, Geddes LA, Bourland JD. The meaning of the point of maximum oscillations in cuff pressure in the indirect measurement of blood pressure—part ii. *J Biomech Eng*. 1980;102:28–33.
  44. Yelderman M, Ream AK. Indirect measurement of mean blood pressure in the anesthetized patient. *Anesthesiology*. 1979;50:253–256.
  45. van Montfrans GA. Oscillometric blood pressure measurement: progress and problems. *Blood Press Monit*. 2001;6:287–290.
  46. Amooe JN, Scott DH. Can simulators evaluate systematic differences between oscillometric non-invasive blood-pressure monitors? *Blood Press Monit*. 2000;5:81–89.
  47. Borow KM, Newburger JW. Noninvasive estimation of central aortic pressure using the oscillometric method for analyzing systemic artery pulsatile blood flow: comparative study of indirect systolic, diastolic, and mean brachial artery pressure with simultaneous direct ascending aortic pressure measurements. *Am Heart J*. 1982;103:879–886.
  48. Wiinberg N, Hoegholm A, Christensen HR, Bang LE, Mikkelsen KL, Nielsen PE, Svendsen TL, Kampmann JP, Madsen NH, Bentzon MW. 24-h ambulatory blood pressure in 352 normal Danish subjects, related to age and gender. *Am J Hypertens*. 1995;8(10 Pt 1):978–986.
  49. Cates EM, Schluskel YR, James GD, Pickering TG. A validation study of the Spacelabs 90207 ambulatory blood pressure monitor. *J Ambul Monitor*. 1990;3:149–154.
  50. Penaz J. Photo-electric measurement of blood pressure, volume and flow in the finger. *Digest Tenth International Conference Medical Biological Engineering*. Dresden; 1973:104.
  51. van Egmond J, Hasenbos M, Crul JF. Invasive v. non-invasive measurement of arterial pressure. Comparison of two automatic methods and simultaneously measured direct intra-arterial pressure. *Br J Anaesth*. 1985;57:434–444.
  52. Parati G, Casadei R, Gropelli A, Di Rienzo M, Mancia G. Comparison of finger and intra-arterial blood pressure monitoring at rest and during laboratory testing. *Hypertension*. 1989;13(6 Pt 1):647–655.
  53. Imholz BPM, Langewouters GJ, van Montfrans GA, Parati G, van Goudoever J, Wesseling KH, Wieling W, Mancia G. Feasibility of ambulatory, continuous 24-hour finger arterial pressure recording. *Hypertension*. 1993;21:65–73.
  54. Ware RW, Laenger CJ. Indirect blood pressure measurement by Doppler ultrasonic kinetoarteriography. *Proc 20th Annual Conference Engineering Medical Biology*. 1967;9:27–30.
  55. Elseed AM, Shinebourne EA, Joseph MC. Assessment of techniques for measurement of blood pressure in infants and children. *Arch Dis Child*. 1973;48:932–936.
  56. Drzewiecki GM, Melbin J, Noordergraaf A. Arterial tonometry: review and analysis. *J Biomech*. 1983;16:141–152.
  57. Smulyan H, Siddiqui DS, Carlson RJ, London GM, Safar ME. Clinical utility of aortic pulses and pressures calculated from applanated radial-artery pulses. *Hypertension*. 2003;42:150–155.
  58. O'Rourke MF. From theory into practice: arterial haemodynamics in clinical hypertension. *J Hypertens*. 2002;20:1901–1915.
  59. Mitchell PL, Parlin RW, Blackburn H. Effect of vertical displacement of the arm on indirect blood-pressure measurement. *N Engl J Med*. 1964;271:72–74.
  60. Wonka F, Thummler M, Schoppe A. Clinical test of a blood pressure measurement device with a wrist cuff. *Blood Press Monit*. 1996;1:361–366.
  61. Sesler JM, Munroe WP, McKenney JM. Clinical evaluation of a finger oscillometric blood pressure device. *DICP*. 1991;25:1310–1314.
  62. Manual, electronic or automated sphygmomanometers. AAMI/CDV-1 SP10. Arlington, VA: Association for the Advancement of Medical Instrumentation; 2002.
  63. O'Brien E, Pickering T, Asmar R, Myers M, Parati G, Staessen J, Mengden T, Imai Y, Waeber B, Palatini P, Gerin W. Working Group on Blood Pressure Monitoring of the European Society of Hypertension International Protocol for validation of blood pressure measuring devices in adults. *Blood Press Monit*. 2002;7:3–17.
  64. Gerin W, Schwartz AR, Schwartz JE, Pickering TG, Davidson KW, Bress J, O'Brien E, Atkins N. Limitations of current validation protocols for home blood pressure monitors for individual patients. *Blood Press Monit*. 2002;7:313–318.
  65. van Popee NM, Bos WJ, de Beer NA, Der Kuip DA, Hofman A, Grobbee DE, Wittman JC. Arterial stiffness as underlying mechanism of disagreement between an oscillometric blood pressure monitor and a sphygmomanometer. *Hypertension*. 2000;36:484–488.
  66. van Ittersum FJ, Wijering RM, Lambert J, Donker AJ, Stehouwer CD. Determinants of the limits of agreement between the sphygmomanometer and the SpaceLabs 90207 device for blood pressure measurement in health volunteers and insulin-dependent diabetic patients. *J Hypertens*. 1998;16:1125–1130.
  67. Grim CE, Grim CM, Li J. Entering medical students who say they have been trained to take blood pressure do not follow American Heart Association guidelines. *Am J Hypertens*. 1999;12.
  68. US Environmental Protection Agency. Mercury Study Report to Congress. Volume 1: Executive Summary. Publication EPA-452/R-97-003. Washington DC: Environmental Protection Agency; 1997.
  69. Von Recklinghausen H. Ueber blutdruckmessung Beim menschen. *Arch Exper Path u Pharmacol*. 1901;46:78–132.
  70. Linfors EW, Feussner JR, Blessing CL, Starmer CF, Neelon FA, McKee PA. Spurious hypertension in the obese patient. Effect of sphygmomanometer cuff size on prevalence of hypertension. *Arch Intern Med*. 1984;144:1482–1485.
  71. Bovet P, Hungerbuler P, Quilindo J, Grettve M-L, Waeber B, Burnand B. Systematic difference between blood pressure readings caused by cuff type. *Hypertension*. 1994;24:786–792 [erratum in: *Hypertension*. 1995;25(4 Pt 1):660].
  72. King GE. Errors in clinical measurement of blood pressure in obesity. *Clin Sci*. 1967;32:223–237.
  73. Arcuri EA, Santos JL, Silva MR. Is early diagnosis of hypertension a function of cuff width? *J Hypertens Suppl*. 1989;7:S60–S61.
  74. Russell AE, Wing LM, Smith SA, Aylward PE, McRitchie RJ, Hassam RM, West MJ, Chalmers JP. Optimal size of cuff bladder for indirect measurement of arterial pressure in adults. *J Hypertens*. 1989;7:607–613.

75. Nielsen PE, Larsen B, Holstein P, Poulsen HL. Accuracy of auscultatory blood pressure measurements in hypertensive and obese subjects. *Hypertension*. 1983;5:122-127.
76. Maxwell MH, Waks AU, Schroth PC, Karam M, Dornfeld LP. Error in blood-pressure measurement due to incorrect cuff size in obese patients. *Lancet*. 1982;2:33-36.
77. Beevers DG, Beevers M, Zezulka AV, Hornby R, Herod J. Standards for blood pressure measuring devices. *BMJ (Clin Res Ed)*. 1987;294:1614.
78. O'Brien E, Atkins N, O'Malley K. Selecting the correct bladder according to distribution of arm circumference in the population (abstr). *Hypertension*. 1993;11:1149-1150.
79. Graves JW, Darby CH, Bailey K, Sheps SG. The changing prevalence of arm circumferences in NHANES III and NHANES 2000 and its impact on the utility of the "standard adult" blood pressure cuff. *Blood Press Monit*. 2003;8:223-227.
80. Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. *JAMA*. 2002;288:1723-1727.
81. Graves JW. Prevalence of blood pressure cuff sizes in a referral practice of 430 consecutive adult hypertensives. *Blood Press Monit*. 2001;6:17-20.
82. Thomas M, Radford T, Dasgupta I. Unvalidated blood pressure devices with small cuffs are being used in hospitals. *BMJ*. 2001;323:398.
83. Manning DM, Kuchirka C, Kaminski J. Miscoffing: inappropriate blood pressure cuff application. *Circulation*. 1983;68:763-766.
84. Marks LA, Groch A. Optimizing cuff width for noninvasive measurement of blood pressure. *Blood Press Monit*. 2000;5:153-158.
85. Singer AJ, Kahn SR, Thode HC, Jr, Hollander JE. Comparison of forearm and upper arm blood pressures. *Prehosp Emerg Care*. 1999;3:123-126.
86. Wessig K, Hollinger S, Schmalzhaf I, Lenz T. Clinical evaluation of the efficacy of the Braun PrecisionSensor oscillometric wrist blood pressure monitor for use on adults versus auscultation as defined by ANSI/AAMI SP10-1992. *Blood Press Monit*. 2000;5:239-245.
87. Altunkan S, Yildiz S, Azer S. Wrist blood pressure-measuring devices: a comparative study of accuracy with a standard auscultatory method using a mercury manometer. *Blood Press Monit*. 2002;7:281-284.
88. Netea RT, Lenders JW, Smits P, Thien T. Influence of body and arm position on blood pressure readings: an overview. *J Hypertens*. 2003;21:237-241.
89. Terent A, Breig-Asberg E. Epidemiological perspective of body position and arm level in blood pressure measurement. *Blood Press*. 1994;3:156-163.
90. Cushman WC, Cooper KM, Horne RA, Meydrech EF. Effect of back support and stethoscope head on seated blood pressure determinations. *Am J Hypertens*. 1990;3:240-241.
91. Peters GL, Binder SK, Campbell NR. The effect of crossing legs on blood pressure: a randomized single-blind cross-over study. *Blood Press Monit*. 1999;4:97-101.
92. Ljungvall P, Thorvinger B, Thulin T. The influence of a heart level pillow on the result of blood pressure measurement. *J Hum Hypertens*. 1989;3:471-474.
93. Netea RT, Lenders JW, Smits P, Thien T. Arm position is important for blood pressure measurement. *J Hum Hypertens*. 1999;13:105-109.
94. Lane D, Beevers M, Barnes N, Bourne J, John A, Malins S, Beevers DG. Inter-arm differences in blood pressure: when are they clinically significant? *J Hypertens*. 2002;20:1089-1095.
95. Wingfield D, Cooke J, Thijs L, Staessen JA, Fletcher AE, Fagard R, Bulpitt CJ. Terminal digit preference and single-number preference in the Syst-Eur trial: influence of quality control. *Blood Press Monit*. 2002;7:169-177.
96. King GE. Influence of rate of cuff inflation and deflation on observed blood pressure by sphygmomanometry. *Am Heart J*. 1963;65:303-306.
97. Thulin T, Andersson G, Schersten B. Measurement of blood pressure-a routine test in need of standardization. *Postgrad Med J*. 1975;51:390-395.
98. Rose G. Standardisation of observers in blood pressure measurement. *Lancet*. 1965;10:673-674.
99. Wen SH, Kramer MS, Joey J, Hanley JA, Usher RH. Terminal digit preference, random error and bias in routine clinical measurement of blood pressure. *J Clin Epidemiol*. 1993;46:1187-1193.
100. Nielsen PE, Oxenbull B, Astvuud K, Gyntelberg F. Auscultatory blood pressure performed by doctor on duty. *Acta Med Scand*. 1975;198:35-37.
101. Wingfield D, Freeman GK, Bulpitt CJ; General Practice Hypertension Study Group (GPHSG). Selective recording in blood pressure readings may increase subsequent mortality. *QJM*. 2002;95:571-577.
102. Paul O, Lepper MH, Phelan WH, Dupertius GW, MacMillan A, McKean H, Park H. A longitudinal study of coronary heart disease. *Circulation*. 1963;28:20-31.
103. Kannel WB, Wolf PA, Verter J, McNamara PM. Epidemiologic assessment of the role of blood pressure in stroke: the Framingham Study. 1970. *JAMA*. 1996;276:1269-1278.
104. Veterans Administration Cooperative Study Group on Antihypertensive Agents. Effects of treatment on morbidity in hypertension. *JAMA*. 1967;202:116-122.
105. La Batide-Alanore A, Chatellier G, Bobrie G, Fofol I, Plouin P-F. Comparison of nurse- and physician-determined clinic blood pressure levels in patients referred to a hypertension clinic: implications for subsequent management. *J Hypertens*. 2000;18:391-398.
106. Graciani A, Banegas JR, Lopez-Garcia E, Diez-Ganan L, Rodriguez-Artalejo F. Assessment of a blood pressure measurement training programme for lay observers. *Blood Press Monit*. 2002;7:251-257.
107. Adams C, Burke V, Beilin LJ. Accuracy of blood pressure measurement and anthropometry among volunteer observers in a large community survey. *J Clin Epidemiol*. 2002;55:338-344.
108. Grim CM, Grim CE. Consumer's guide to BP measurement: an informed consumer's guide to accurate BP measurement. In: *The Hypertension Notebook 1996 Shared Care*. IgA nephropathy support group. 2003. Available at <http://www.igan.ca/id57.htm>. Accessed December 2004.
109. University of Aberdeen Medi-CAL unit web site. <http://www.abdn.ac.uk/medical/bhs/tutorial/tutorial.htm> (accessed June 2004).
110. Hutton P, Dye J, Prys-Roberts C. An assessment of the Dinamap 845. *Anaesthesia*. 1984;39:261-267.
111. Rose KM, Arnett DK, Ellison RC, Heiss G. Skip patterns in DINAMAP-measured blood pressure in 3 epidemiological studies. *Hypertension*. 2000;35:1032-1036.
112. Edmonds ZV, Mower WR, Lovato LM, Lomeli R. The reliability of vital sign measurements. *Ann Emerg Med*. 2002;39:233-237.
113. Backer HD, Decker L, Ackerson L. Reproducibility of increased blood pressure during an emergency department or urgent care visit. *Ann Emerg Med*. 2003;41:507-512.
114. Hunt RC, Carroll RG, Whitley TW, Bryan-Berge DM, Dufresne DA. Adverse effect of helicopter flight on the ability to palpate carotid pulses. *Ann Emerg Med*. 1994;24:190-193.
115. Talke PO. Measurement of systolic blood pressure using pulse oximetry during helicopter flight. *Crit Care Med*. 1991;19:934-937.
116. Prasad NH, Brown LH, Ausband SC, Cooper-Spruill O, Carroll RG, Whitley TW. Prehospital blood pressures: inaccuracies caused by ambulance noise? *Am J Emerg Med*. 1994;12:617-620.
117. Jones JS, Ramsey W, Hetrick T. Accuracy of prehospital sphygmomanometers. *J Emerg Med*. 1987;5:23-27.
118. Whitcomb BL, Prochazka A, LoVerde M, Byyny RL. Failure of the community-based Vita-Stat automated blood pressure device to accurately measure blood pressure. *Arch Fam Med*. 1995;4:419-424.
119. Salaita K, Whelton PK, Seidler AJ. A community-based evaluation of the Vita-Stat automatic blood pressure recorder. *Am J Hypertens*. 1990;3(5 Pt 1):366-372.
120. Whelton PK, Thompson SG, Barnes GR, Miall WE. Evaluation of the Vita-Stat automatic blood pressure recorder. A comparison with the Random-Zero sphygmomanometer. *Am J Epidemiol*. 1983;117:46-54.
121. Polk BF, Rosner B, Feudo R, Vandenburg M. An evaluation of the Vita-Stat automatic blood pressure measuring device. *Hypertension*. 1980;2:221-227.
122. Lewis JE, Boyle E, Magharious L, Myers MG. Evaluation of a community-based automated blood pressure measuring device. *CMAJ*. 2002;166:1145-1148. [erratum in: *CMAJ*. 2002;166:1512].
123. Kleinert HD, Harshfield GA, Pickering TG, Devereux RB, Sullivan PA, Marion RM, Mallory WK, Laragh JH. What is the value of home blood pressure measurement in patients with mild hypertension? *Hypertension*. 1984;6:574-578.
124. O'Brien E, Waeber B, Parati G, Staessen J, Myers MG. Blood pressure measuring devices: recommendations of the European Society of Hypertension. *BMJ* 2001;322:531-536.
125. O'Brien E. State of the market for devices for blood pressure measurement. *Blood Press Monit*. 2001;6:281-286.
126. Dabl educational web site. <http://www.dableducational.com>. Accessed 8/19/2004.



127. Cooper R, Puras A, Tracy J, Kaufman J, Asuzu M, Ordunez P, Mufunda J, Sparks H. Evaluation of an electronic blood pressure device for epidemiological studies. *Blood Press Monit.* 1997;2:35–40.
128. Stahl SM, Kelley CR, Neill PJ, Grim CE, Mamlin J. Effects of home blood pressure measurement on long-term BP control. *Am J Public Health.* 1984;74:704–709.
129. Vrijens B, Goetghebeur E. Comparing compliance patterns between randomized treatments. *Control Clin Trials.* 1997;18:187–203.
130. Edmonds D, Foerster E, Groth H, Greminger P, Siegenthaler W, Vetter W. Does self-measurement of blood pressure improve patient compliance in hypertension? *J Hypertens Suppl.* 1985;3:S31–S34.
131. Mengden T, Hernandez Medina RM, Beltran B, Alvarez E, Kraft K, Vetter H. Reliability of reporting self-measured blood pressure values by hypertensive patients. *Am J Hypertens.* 1998;11:1413–1417.
132. Myers MG. Self-measurement of blood pressure at home: the potential for reporting bias. *Blood Press Monit.* 1998;3(suppl 1):S19–S22.
133. Moller DS, Dideriksen A, Sorensen S, Madsen LD, Pedersen EB. Accuracy of telemedical home blood pressure measurement in the diagnosis of hypertension. *J Hum Hypertens.* 2003;17:549–554.
134. Tsuji I, Imai Y, Nagai K, Ohkubo T, Watanabe N, Minami N, Itoh O, Bando T, Sakuma M, Fukao A, Satoh H, Hisamichi S, Abe K. Proposal of reference values for home blood pressure measurement: prognostic criteria based on a prospective observation of the general population in Ohasama, Japan. *Am J Hypertens.* 1997;10(4 Pt 1):409–418.
135. Imai Y, Ohkubo T, Tsuji I, Nagai K, Satoh H, Hisamichi S, Abe K. Prognostic value of ambulatory and home blood pressure measurements in comparison to screening blood pressure measurements: a pilot study in Ohasama. *Blood Press Monit.* 1996;1(Suppl 2):S51–S58.
136. Ohkubo T, Imai Y, Tsuji I, Nagai K, Ito S, Satoh H, Hisamichi S. Reference values for 24-hour ambulatory blood pressure monitoring based on a prognostic criterion: the Ohasama Study. *Hypertension.* 1998;32:255–259.
137. Pickering T. Recommendations for the use of home (self. and ambulatory blood pressure monitoring. American Society of Hypertension Ad Hoc Panel. *Am J Hypertens.* 1996;9:1–11.
138. Ibrahim MM, Tarazi RC, Dustan HP, Gifford RW Jr. Electrocardiogram in evaluation of resistance to antihypertensive therapy. *Arch Intern Med.* 1977;137:1125–1129.
139. Verdecchia P, Bentivoglia M, Providenza M, Savino K, Corea L. Reliability of home self-recorded arterial pressure in essential hypertension in relation to the stage of the disease. In: Germano G, ed. *Blood pressure recording in the clinical management of hypertension.* Rome: Ediziono Pozzi; 1985:40–42.
140. Abe H, Yokouchi M, Saitoh F, Deguchi F, Kimura G, Kojima S, Yoshimi H, Ito K, Kuramochi M, Ikeda M, et al. Hypertensive complications and home blood pressure: comparison with blood pressure measured in the doctor's office. *J Clin Hypertens.* 1987;3:661–669.
141. Rogers MA, Small D, Buchan DA, Butch CA, Stewart CM, Krenzer BE, Husovsky HL. Home monitoring service improves mean arterial pressure in patients with essential hypertension. A randomized, controlled trial. *Ann Intern Med.* 2001;134:1024–1032.
142. Utility of blood pressure monitoring outside of the clinic setting. Evidence report/technology assessment number 03-E004. Rockville MD: Agency for Healthcare Research and Quality; 2002.
143. Clement DL, De Buyzere ML, De Bacquer DA, de Leeuw PW, Duprez DA, Fagard RH, Gheeraert PJ, Missault LH, Braun JJ, Six RO, Van Der NP, O'Brien E; Office versus Ambulatory Pressure Study Investigators. Prognostic value of ambulatory blood-pressure recordings in patients with treated hypertension. *N Engl J Med.* 2003;348:2407–2415.
144. Perloff D, Sokolow M, Cowan R. The prognostic value of ambulatory blood pressure monitoring in treated hypertensive patients. *J Hypertens Suppl.* 1991;9:S33–S39.
145. Staessen JA, Asmar R, De Buyzere M, Imai Y, Parati G, Shimada K, Stergiou G, Redon J, Verdecchia P; Participants of the 2001 Consensus Conference on Ambulatory Blood Pressure Monitoring. Task Force II: blood pressure measurement and cardiovascular outcome. *Blood Press Monit.* 2001;6:355–370.
146. Verdecchia P, Porcellati C, Schillaci G, Borgioni C, Ciucci A, Battistelli M, Guerrieri M, Gatteschi C, Zampi I, Santucci A, et al. Ambulatory blood pressure. An independent predictor of prognosis in essential hypertension. *Hypertension.* 1994;24:793–801. [erratum in: *Hypertension.* 1995;25:462].
147. Khattar RS, Senior R, Lahiri A. Cardiovascular outcome in white-coat versus sustained mild hypertension: a 10-year follow-up study [see comments]. *Circulation.* 1998;98:1892–1897.
148. Redon J, Campos C, Narciso ML, Rodicio JL, Pascual JM, Ruilope LM. Prognostic value of ambulatory blood pressure monitoring in refractory hypertension: a prospective study. *Hypertension.* 1998;31:712–718.
149. Kario K, Shimada K, Schwartz JE, Matsuo T, Hoshida S, Pickering TG. Silent and clinically overt stroke in older Japanese subjects with white-coat and sustained hypertension. *J Am Coll Cardiol.* 2001;38:238–245.
150. Ohkubo T, Imai Y, Tsuji I, Nagai K, Watanabe N, Minami N, Kato J, Kikuchi N, Nishiyama A, Aihara A, Sekino M, Satoh H, Hisamichi S. Relation between nocturnal decline in blood pressure and mortality. The Ohasama Study. *Am J Hypertens.* 1997;10:1201–1207.
151. Staessen J, Thijs L, Fagard R, O'Brien E, Clement D, de Leeuw PW, Mancia G, Nachev C, Palatini P, Parati G, Tuomilehto J, Webster J. Predicting cardiovascular risk using conventional vs ambulatory blood pressure in older patients with systolic hypertension. Systolic Hypertension in Europe Trial Investigators. *JAMA.* 1999;282:539–546.
152. Sykes D, Dewar R, Mohanaruban K, Donovan K, Nicklason F, Thomas DM, Fisher D. Measuring blood pressure in the elderly: does atrial fibrillation increase observer variability? *BMJ.* 1990;300:162–163.
153. Stewart MJ, Gough K, Padfield PL. The accuracy of automated blood pressure measuring devices in patients with controlled atrial fibrillation. *J Hypertens.* 1995;13:297–300.
154. Olsen R, Amlie A, Omvik P. Twenty-four-hour ambulatory blood pressure monitoring in atrial fibrillation. *Blood Press Monit.* 2002;7:149–156.
155. Lip GY, Zarifis J, Beevers M, Beevers DG. Ambulatory blood pressure monitoring in atrial fibrillation. *Am J Cardiol.* 1996;78:350–353.
156. Warembourg A, Poncelet P, Carre A. [Reliability of the measurement of arterial pressure in the forearm in the obese subject]. *Arch Mal Coeur Vaiss.* 1987;80:1015–1019.
157. Prineas RJ, Elkwyry ZM. Epidemiology and measurement of high blood pressure in children and adolescents. In: Loggie JMH, ed. *Pediatric and Adolescent Hypertension.* Boston, MA: Blackwell Scientific Publications; 1992:91–103.
158. Sinaiko AR, Gomez-Marin O, Prineas RJ. Diastolic fourth and fifth phase blood pressure in 10–15-year-old children. The Children and Adolescent Blood Pressure Program. *Am J Epidemiol.* 1990;132:647–655.
159. National High Blood Pressure education Program Working Group on Hypertension Control in Children and Adolescents. Update on the 1987 Task Force Report on High Blood Pressure in children and Adolescents: A Working Group Report from the National High Blood Pressure Education Program. *Pediatrics.* 1996;98:649–658.
160. Lurbe E, Redon J, Liao Y, Tacons J, Cooper RS, Alvarez V. Ambulatory blood pressure monitoring in normotensive children. *J Hypertens.* 1994;12:1417–1423.
161. Wuhl E, Witte K, Soergel M, Mehls O, Schaefer F, Kirschstein M, Busch C, Danne T, Gellermann J, Holl R, Krull F, Reichert H, Reusz GS, Rascher W; German Working Group on Pediatric Hypertension. Distribution of 24-h ambulatory blood pressure in children: normalized reference values and role of body dimensions. *J Hypertens.* 2002;20:1995–2007. [erratum in: *J Hypertens.* 2003;21:2205–2206].
162. Brown MA, Davis GK. Hypertension in pregnancy. In: Mancia G, Chalmers J, Julius S, Saruta T, Weber MA, Ferrari AU, Wilkinson IB, ed. *Manual of Hypertension.* London: Harcourt Publishers Limited; 2002:579–597.
163. Waugh JJ, Halligan AW, Shennan AH. Ambulatory monitoring and self-monitoring of blood pressure during pregnancy. *Blood Press Monit.* 2000;5:3–10.
164. Feldman DM. Blood pressure monitoring during pregnancy. *Blood Press Monit.* 2001;6:1–7.



**Recommendations for Blood Pressure Measurement in Humans and Experimental Animals: Part 1: Blood Pressure Measurement in Humans: A Statement for Professionals From the Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research**

Thomas G. Pickering, John E. Hall, Lawrence J. Appel, Bonita E. Falkner, John Graves, Martha N. Hill, Daniel W. Jones, Theodore Kurtz, Sheldon G. Sheps and Edward J. Roccella

*Hypertension*. 2005;45:142-161; originally published online December 20, 2004;  
doi: 10.1161/01.HYP.0000150859.47929.8e

*Hypertension* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231  
Copyright © 2004 American Heart Association, Inc. All rights reserved.  
Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://hyper.ahajournals.org/content/45/1/142>

**Permissions:** Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Hypertension* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the [Permissions and Rights Question and Answer](#) document.

**Reprints:** Information about reprints can be found online at:  
<http://www.lww.com/reprints>

**Subscriptions:** Information about subscribing to *Hypertension* is online at:  
<http://hyper.ahajournals.org/subscriptions/>